University of Alberta

I Don't Want to Live: The Emotional Process of Suicidality

by

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Dedication

To my mother, Eileen, who has provided unwavering emotional support throughout my academic career.

Abstract

This study explored the emotional process of being suicidal from the perspective of suicidal clients who have received psychotherapy. Research into the emotional process in psychotherapy has concluded that the resolution of emotions is necessary for recovery. Whether recovery is facilitated in the same way for suicidal persons as nonsuicidal persons is unknown because emotional processes have been largely ignored in suicidology. Six Caucasian females and two Caucasian males with a mean age of 44.5 participated in the study. Length of therapy averaged four years. All participants were previously suicidal and they reported having made at least one serious suicide attempt. Grounded theory methods were used to analyze two complimentary data sources: eight in-depth, semi-structured interviews and diary entries from four of the eight participants. Analysis consisted of grounded theory techniques of theoretical sampling, constant comparative analysis, and memo writing. The emotional process of being suicidal is conceptualized in the core category, Developing Emotional Awareness. Participants' emotional awareness developed from Initial Emotional Awareness to Integrative Emotional Awareness, with increased coping skills being the marker of that movement. This developing insight was found to consist of three stages, Compressing, Blocking, and Allowing emotions. Emotions identified in suicidal individuals included Powerlessness, Despair, Isolation, and Fear. As participants went through the stages, increasing awareness facilitated an expansion of coping skills, such as broadening perspectives, problem-solving skills, tolerating the pain, controlling the intensity of emotions, and reserving the option of suicide. Participants reported that stressors did not change significantly throughout the process. Rather, coping skills were developed via awareness. This study increased our understanding of suicidal persons' emotional processes, which can inform mental health professionals in preventing suicide and improving treatment and training. These findings support the use of an emotionally focused-approach when working with suicidal individuals. Specifically, the implications for treatment include the need for collaborative, empathic, and validating therapeutic experiences where talking about suicide and feelings is acceptable. Training and supervision should attend to the clinician's comfort level in working with suicidal individuals.

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Chapter One

Introduction

The purpose of this study was to understand the emotional process of being suicidal. Until now, therapists' clinical experience and a myriad of demographic information have largely informed psychotherapy and assessment with suicidal persons. Less well known is the experience of the suicidal person, especially the emotional process of the suicidal person, despite the finding that the emotional process is related to recovery from suicidality (Bolger, 1999; Clark, 1996; Greenberg & Safran, 1990; Paulson & Worth, 2002). This chapter places the study within the broader field of counselling research and it sets the stage for an examination of theory and empirical research on emotions and suicide. It also highlights background influences and the purpose of the study.

Research Question

This study was guided by the question, *what is the emotional process of being suicidal?* Preventative measures cannot excel beyond the influence of existing knowledge of demographics of suicide on assessment procedures because not enough is known about the subjective experience of being suicidal. It is known that the emotional process of being suicidal is crucial to recovery from suicidal feelings (Paulson & Worth, 2002). This study aimed to give deeper expression to that experience from the suicidal person's perspective. The process or stages that one's emotions move through when one is suicidal were explored.

Qualitative researchers acknowledge that the researcher shapes and influences the research and subsequent interpretation (Osborne, 1990). Several matters shaped and influenced this research (see Appendix A). Among them were my observations and experiences with client emotional releases and from the curiosity developed in my involvement with other suicide research. What is it like to be in the shoes of a client who has experiences that may or may not be shared with the therapist? For example, I wondered how a client processes emotions outside of the session and how this experience influences therapeutic progress. I also wondered if this process is different for suicidal persons. This type of knowledge is beneficial in providing an empathic and safe environment within which the client can freely explore his or her life circumstances, especially in the case of suicide ideation, which holds so much secrecy. The research question was born of my interests in client emotional process and suicide and is augmented by the literature review in the following chapter.

Purpose and Scope of the Study

Initially, the purpose of the study was to investigate the emotional process of previously suicidal clients in counselling to better understand that process. However, it became clear in the initial interviews and in the diaries that it was important for participants to communicate the emotional process happening outside of the psychotherapy session as well. The flexibility of grounded theory methods of analysis allowed me to follow this path when it became clear to me that therapists needed to know more about the emotional process of being suicidal before limiting investigations to psychotherapy. As such, the scope of this research was broadened to encompass clients' emotional process of being suicidal, in keeping with Asay and Lambert's (1999) case for including extratherapeutic change when understanding improvement in psychotherapy. The primary purpose of this research, then, was to gain an understanding of the emotional process of being suicidal in order to inform prevention measures and psychotherapy with suicidal clients. The scope of this study encompasses previously suicidal persons who have had psychotherapy in the context of attempted suicide, rather than completed suicide.

This research is a necessary endeavour in psychotherapy for two related reasons. First, the need for this research is prescribed by the fact that all therapists will inevitably meet with a client who is thinking about suicide (Dexter-Mazza & Freeman, 2003), whether or not it is disclosed. This state of affairs reflects a supply-demand issue. The demand for knowledge of the experience of being suicidal has been expressed but the current state of research remains in the organizing phase of providing that knowledge. The second reason follows from the first. The fact that suicide and attempted suicide continue to be social and psychological problems indicates that there continues to be a need for a greater understanding of suicide. It is my hope that this research will provide a solid base for understanding the complexity of the suicidal experience. Overall, my intentions have a practical purpose, although these results may inform future theoretical endeavours.

The importance of conducting research on suicidal clients' emotional experience stems from the potential benefits of this understanding to treatment. It may allow counsellors insight into clients' unspoken and ambiguous processes. This insight is assumed to provide increased awareness and understanding of the clients' internal experience regarding emotions they bring to psychotherapy and emotions experienced outside the session, and the effects of those emotions on their recovery from high lethality. Overall, a clearer understanding of clients' emotional experience will contribute to more productive and supportive client-focused sessions.

Counselling Research

Changes in the major phases of counselling research over the years provide the foundation for understanding the suitability of the methodology and methods of analysis used in this study. The changes are described here in the context of process versus outcome research and quantitative versus qualitative methods. Counselling process refers to "client and therapist activities and experiences during the course of therapy" (Orlinsky & Russell, 1994) whereas counselling outcome refers to the changes that happen as a result of counselling (Hill & Corbett, 1993). Some variables may be treated as outcome or process variables, such as client satisfaction (Hill & Corbett). Other variables, such as client commitment, client readiness, and counsellor encouragement are more clearly process variables because they change from moment to moment.

The history of psychotherapeutic research reflects a circular use of process and outcome research. Orlinsky and Russell (1994) organized the history of psychotherapy research into four phases. The main concern of investigators in the first phase (c. 1927-1954) was to establish the role of scientific methods in psychotherapy. Although early researchers attended to process, pressure from health service providers demanded more objective data to demonstrate accountability for services. This phase was characterized by using audio sound recordings of sessions. The resulting focus on the efficacy of counselling through outcome research was intended to make the research on process more meaningful (Hill & Corbett, 1993).

The second phase of psychotherapy research (c. 1955-1969) was characterized by the challenge of establishing scientific rigor for both process and outcome research (Orlinsky & Russell, 1994). Much of the process research in this phase focused on establishing the validity of Rogers' (1957) conditions of therapeutic change but the use of objective measures to document subjective experiences was incongruent (Mitchell, Bozarth, & Krauft, 1977).

The third phase of psychotherapy research (c. 1970-1983) was marked by the organized communication of the results of past and current research endeavours. This phase was partially characterized by the introduction of the statistical technique of meta-analysis in affirming the effectiveness of psychotherapy (Asay & Lambert, 1999; Kelly, 1996; Orlinsky & Russell, 1994). In this phase, psychotherapeutic research failed to identify the superior efficacy of any specific treatment methods (Orlinsky & Russell; Shapiro et al., 1994; Stiles, Shapiro, & Elliott, 1986), suggesting that effective change ingredients are evident across many theoretical approaches. This knowledge provided an invitation for researchers to focus more on the process of change (Greenberg, 1994) and less on specific interventions or theoretical orientation.

Thus, the most recent shift directed investigations towards process in order to access factors responsible for positive therapeutic change (Beutler, 2000; Cummings & Hallberg, 1995). Orlinsky and Russell (1994) characterize this period (c. 1984-Present) as one of dissatisfaction with past methods, which were primarily quantitative. Many (e.g., Greenberg, 1994; Orlinsky & Russell) urged researchers to discover the phenomenon before verifying it or to adopt epistemological eclecticism in their methods (Polkinghorne, 1991).

Qualitative and quantitative methods are complementary methods of gaining insight and knowledge, prescribed by the question proposed by the researcher, a question that is usually based on the needs of the area of study. Right now, those research needs are to further understand the counselling process. Experimental designs are ill-suited to research interests in an area that is not experimental in nature (Orlinsky, Rønnestad, & Willutzki, 2004), thereby prescribing the use of qualitative methods. Orlinsky et al. surveyed process-outcome studies conducted between 1993 and 2001. Despite the acknowledgement of emotion as an important process variable in the psychotherapy process, valuable process studies were excluded from their survey based on strict inclusion criteria. Rather, they found that research on the emotional aspects of psychotherapy was limited to studies examining verbalization and nonverbalization of emotions, the acceptance of one's feelings in the context of self-relatedness, and emotional relief, all of which are specific aspects of a larger, more abstract emotion process.

The most recent prescription for qualitative methods evolved from this circular use of process and outcome research, but qualitative methods are also congruent with the inherent nature of counselling as a process of change. It follows that growth curves fluctuate over time and therefore limit the benefits of looking at progress as a linear concept in counselling (Hill & Corbett, 1993). The outcome is always changing. Process research is the bridge to understanding that changing outcome. It seeks to answer the most pressing current question for research in counselling, *How does counselling work?* as opposed to *What effect does counselling have?* the latter of which has already been determined.

Emotions as Process Variables

Researchers have alluded to several process variables in counselling. They include the therapeutic alliance, client perspective, cognitive insight and change, emotions in psychotherapy, client expectations (Asay & Lambert, 1999; Walborn, 1996), empathy, self-understanding, guided discovery (Hoffart, Versland, & Sexton, 2002), and therapists' perceptions of the working alliance (Nutt-Williams & Hill, 1996). Cognitions and the therapeutic alliance have gained greater attention than emotions until recently. However, practitioners are increasingly attributing therapeutic change to clients' emotional experiences. The contention that facilitating emotional experiences in counselling is related to positive outcome (Arnkoff & Glass, 1992; Clark, 1996; Greenberg & Safran, 1990; Klein, Mathieu-Coughlan, & Kiesler, 1986; Leahy, 2003; Orlinksy & Howard, 1986) has helped to establish the role of emotions as active change agents in counselling (Paivio & Greenberg, 2001).

This study is not confined to emotions in the counselling process. Rather, it explores the emotional process of being suicidal in persons who have had psychotherapy. Stages of this emotional process are not shut off after a psychotherapy session. There is much to know about this process before research efforts focus on the emotional process in counselling. Greenberg and Paivio (1997) propose that "emotions involve a natural process of emergence and completion" (p. 26). The process begins with an emotion emerging, coming into awareness, owning the emotion and allowing expressive action, finally moving to the completion of an emotion, followed then by another emotion. The intent of this study is to capture those stages in a suicidal person. A better knowledge of these stages is beneficial information for clinicians treating suicidal clients.

Suicide Research

Data compiled by Statistics Canada (2001, 2002) illustrate the enormity of the problem of suicide with the following statistics:

1. In 2001, 3688 people completed suicide in Canada, 2870 and 818 for males and females, respectively.
2. The suicide rate in Canada has remained stable since the early 1990s, following a steady increase and peak in the early 1980s.
3. Generally, the suicide rate has increased by 10% since 1986 for both sexes, although the rate for males exceeded that of females by 3.8%.
4. Teen suicides fell 6% and people in their 40s accounted for almost 25% of the suicides, up 24% from 1998.
5. Canada's suicide rate exceeds the death rate for motor vehicle crashes and the death rate for homicide.

Clearly the suicide situation in Canada is not improving. As suicide remains one of the leading causes of death, the potential effects of this research on the understanding of being suicidal and the prevention of completed suicides are enormous.

Suicide is a commonly encountered reality for counsellors working across all settings (Westefeld et al., 2000). In fact, Dexter-Mazza and Freeman (2003) found that approximately 99% of graduate students treat at least one suicidal client during their graduate training. With no reduction in the suicide rates in Canada and the United States (Statistics Canada, 2001, 2002; National Center for Health Statistics [NCHS], 2003), it is a serious mental health concern. Little is known about how to treat suicidal clients or all the elements involved in their experience. In particular, less is known about the emotional experiences of suicidal clients, even though facilitating the emotional experiences of nonsuicidal clients is thought to help the healing process for nonsuicidal clients (Arnkoff &

Glass, 1992; Clark, 1996; Greenberg & Safran, 1990; Klein et al., 1986; Orlinksy & Howard, 1986; Stuart, 2002). Thus, the importance of understanding suicidal clients' emotional experiences is paramount for the helping profession.

There exists limited research on the experience of suicidal clients despite the vast amount of literature attending to the symptomotology and characteristics of suicidal individuals. So far, researchers have investigated previously suicidal clients' perceptions of helpful therapeutic conditions (Paulson & Worth, 2002) and identified relationships, emotions, and identity as factors in this process. Others (Iancu et al., 1999) addressed emotions more specifically in the suicidal patient and found that suicidal patients experience greater intensity of emotions. This finding suggests that suicidal clients may experience emotions differently than nonsuicidal clients and directs our attention to the importance of studying suicidal clients' emotional experiences. Active measures must be taken to understand the emotional process of suicide to proactively address the suicide rate. The current state of the literature indicates a need for qualitative descriptions of the emotional process of being suicidal. Such research augments existing knowledge on the emotional process of nonsuicidal clients and the current demographic flavour of suicide research.

Summary

Despite an abundance of demographic information regarding suicidal persons, the emotional process of being suicidal has yet to be uncovered. Given the seriousness of suicidal behaviour and its consequences, as well as the internal nature of suicidal feelings, research on the suicidal person's perspective is needed. Suicide outcomes are already known. There remains a need to investigate the process of being suicidal so that therapists may be in a better position to facilitate change in outcomes, specifically to prevent lethal outcomes. Previous research has directed us toward the emotional process (Paulson & Worth, 2002) in this respect. Therapists are in a crucial position when working with suicidal clients but an absence of knowledge and comprehension of being suicidal impedes our ability to understand and improve prevention, treatment, and training. Given this state of affairs, this study was designed to develop an understanding of the emotional process of being suicidal, from the perspective of clients who have had psychotherapy. Grounded theory methods of analysis (Glaser & Strauss, 1967) were chosen primarily for their specialization in studying *process*.

Following a review of emotion and suicide theory and research in Chapter Two, the rational and procedures for the use of grounded theory methods of analysis of in-depth interviews and diaries is explained in Chapter Three. Results are presented in Chapter Four in an exploratory flavour, rich with descriptions from data sources. Results are further discussed in Chapter Five in the context of existing literature. Implications for practice and future research are also presented in this last chapter.

Chapter Two

Literature Review

This chapter explores the literature pertinent to this investigation, specifically, theory and research related to emotion and suicide. It places this study within the current state of emotion and suicide knowledge. Existing theory and research on emotions is examined from three perspectives that include the conceptualization of emotions, emotions in psychotherapeutic theory, and empirical research on emotions in psychotherapy. The suicide literature is analyzed according to similar domains: the conceptualization of suicide, suicide theory, and empirical research on suicide in psychotherapy. This literature review supports the need to better understand the emotional process of being suicidal.

Conceptualizing Emotion

The concept of emotion and what makes up an emotion has been a matter of debate and disagreement. A diversity of perspectives abound the literature, proving that emotions are complex and not well understood. Nonetheless, all would agree that "emotions are action readiness changes in response to events relevant to the individual's concerns" (Frijda, 1986, p. 371). First, emotions will be distinguished from similar concepts, such as mood and feelings. Then, the major components of an emotion will be presented. This section will end with a discussion of these components in the context of the major theoretical perspectives on emotion.

The terms *emotions, affects, moods,* and *feelings* have been used interchangeably in the literature, making it difficult to sort out theory and research. Greenberg and Paivio (1997) provide the most consistent and integrative process-oriented differentiation of these concepts. They define affect as the unconscious, adaptive, biological response to stimulation. This reflexive nature of affect leads to conscious processes involved in emotions and feelings, where feelings involve the bodily sensation that bring the affect into awareness. Once in conscious awareness, the specific emotions are experiences that connect action tendencies and feelings states with situations and self. In this conceptualization, emotions consist of a discrete context of processes, including affect and feelings (Greenberg & Paivio), as well as broader contextual processes, such as evolutionary, neurological, cognitive, and developmental influences (Plutchik, 1984). As such, discrete emotions, such as anger and sadness, cannot be understood out of the context of the broader emotional experience.

Others (e.g., Damasio, 2003) suggest that the complex emotional process begins with emotion and transfers into feeling. Perls, Hefferline, and Goodman (1951) place feelings and emotions on a continuum with feelings representing less violent phenomenon whereas emotions are fully conscious volcanic instances. Whether a feeling erupts into an emotion depends on the importance or concern about that aspect of the environment to the individual. Moods are the longer-term, generalized experience of emotions (Damasio; Lazarus, 1984). Although others have grouped moods, affect, and feelings into a general and enduring trait category in relation to the discrete, acute, and brief nature of specific emotions (Frijda, 2000; Rosenberg, 1998), Greenberg and Paivio's (1997) explanation will be used for the purposes of having a common language throughout this document.

The major emotion perspectives include Frijda's (1986) evolutionary view (Darwin, 1872/1955), William James' physiological perspective (James, 1884/1983), LeDoux's (1993, 1996) neurological view, Lazarus' (1991) cognitive view, Averill's (1980) constructivist view, and Greenberg's integrative view (Greenberg & Paivio, 1997). Despite the complexity of emotions and controversy about their make-up, these emotion theorists generally agree that emotions have five main components:

1. *Bodily-felt experiences.* Emotions "activate widespread physiological

adjustments to the arousing conditions" (Plutchik, 1994, p. 5). These physiological changes (Lazarus, 1984) or bodily-felt sensations (Greenberg & Paivio, 1997) are not caused by physical conditions (Frijda, 2000) and they inform the person to act.

2. *Information-processing systems*. Emotions have two types of information processing systems (Frijda, 1986; Greenberg & Paivio, 1997). One is cognitive, the other is affective/emotional but with a cognitive component.
3. *Appraisal mechanism*. Emotions "generate cognitive processes such as emotionally relevant perceptual effects, appraisals, labelling processes" (Plutchik, 1994, p. 5). As such, emotions help to appraise the environment according to concern to the self, harms and benefits to the self, and general meaning to the self. Emotions interact with cognition appraisal to prepare one to act on one's behalf. For example, consider a relationship ending for oneself versus a relationship ending for a friend. In the absence of matters of concern about the self, such as a relationship ending for a friend, emotions are not as prominent or intense.
4. *Motivation*. Emotions have a motivational component that influences a person's readiness and preparedness to act (Frijda, 1986). These action impulses (Lazarus, 1984) lead to behaviour that is often, but not always, expressive, goal-directed, and adaptive (Plutchik, 1994, p. 5).
5. *Subjective feeling*. "Emotion is a complex set of interactions among subjective and objective factors, mediated by neural/hormonal systems" (Plutchik, 1994, p. 5). The subjective feeling is the emotion coming into consciousness. It is the awareness of the need to feel any given emotion (e.g., sadness). This subjective component is of particular interest in this study.

All these components communicate meaning - what in the environment is of issue or concern or importance to the self. Plutchik (2000) considers the complexity of these components of emotion by highlighting major emotion properties, such as communication and survival, genetic influences, the existence of a primary emotion basis to other emotions and traits, the relationship among intensity, similarity, and polarity of emotions, and the influences of conceptual domains such as traits, personality disorders, ego defences, and coping styles.

The following discussion examines these five components of emotion in the context of evolutionary, neurological, cognitive, and developmental perspectives of emotion. Generally, emotions are based in the neurological level (LeDoux, 1993) with conscious awareness occurring at the physiological (Greenberg & Paivio, 1997), subjective, and cognitive levels with influences on motivation and action (Frijda, 1993; Greenberg & Paivio; Izard & Ackerman, 2000).

Evolutionary Aspects of Emotion. The main contribution of the evolutionary perspective is the implication of emotions in matters of adaptation (Frijda, 2000), especially with respect to motivation and action readiness (Frijda, 1986). From the evolutionary perspective is the idea that emotions are fundamentally adaptive (Darwin, 1872/1955; Frijda; Greenberg & Paivio, 1997), especially in the absence of learning alternate ways of experiencing a situation (Greenberg & Paivio). Emotions are "patterns of adaptation that increase the chances of individual and genetic survival" (Plutchik, 2000, p. 79). It is the state of action readiness and the motivational tendency toward action readiness that makes emotions highly adaptive. Of course, there have been major changes in the events that provoke emotional experiences over the years, such as the traditional stimuli involved in running from danger versus the modern stimuli involved in giving a presentation.

Emotions have two primary functions, they identify matters of concern to the self and they are social regulators (Frijda, 1994b). Both functions have an evolutionary basis whereby emotions assist the self in dealing with the environment. Some emotions, such as shame and guilt, serve a preventative function in protecting the self and encouraging the self to take precautions against behaviours resulting in uncomfortable emotions, such as guilt, a motivation for more constructive social behaviour (Frijda). These same emotions become dysfunctional when there is no clear connection to a social transgression, such as in the case of guilt (Frijda).

The adaptive nature of emotions may be further understood by examining fluctuations in the awareness of emotion and in the intensity of emotion. For example, Rothbaum, Weisz, and Snyder (1982) postulate that passivity saves energy and allows meaning change to take place. Rothbaum and his colleagues refer to this phenomenon as "secondary coping". Bolles and Fanselow (1980) further hypothesize that deep physical pain motivates immobility that helps recuperation. Frijda refers to these studies (Bolles & Fanselow; Rothbaum et al.) in adaptation matters of emotion, and hypothesizes that passivity or immobility is functional and adaptive.

Neurological Aspects of Emotion. This evolutionary mechanism is played out in the neurological structures of the brain as an automatic, unconscious affective system. Another slower, cognitive, conscious system, also including an affective component gives greater emphasis to cognition. LeDoux (1989) provides a neurological perspective on these two information processing systems. He endorsed the pre-conscious, subcortical activation of emotions implied by James' (1884/1983) proposition that physiological sensation precedes emotion. In the first pathway, the emotion is directly produced when the amygdala senses danger. This first emotion-processing system has evolutionary roots. However, it is unclear how the amygdala differentiates danger without the use of higher limbic activities, only than to speculate that the first pathway consists of responses that have already been learned, and are therefore automatic.

The first system does not require conscious thought but it leads to actions, such as in the case of running in response to seeing a bear. Empirical evidence for this separate automatic affective system exists (Winkielman, Zajonc, & Schwarz, 1997). The dissimilarity of the two points of view is unclear, namely, Zajonc's (1984) acknowledgement of the need for some level of cognition in the affective system versus Lazarus' (1984) automatic affective reaction involving cognitive appraisal, except for findings of separate pathways (Winkielman et al.). The primary brain structure in the first system is the amydgala (LeDoux, 1989) which communicates the significance of stimuli with the neo-cortex and hippocampus. The second pathway involves conscious awareness in the process of relaying inputs from the thalamus to the cortex and then to subcortical structures. It carries information through the thalamus and cortex in a slower process that allows for cognitions and emotional responses before action. Implications of the two different pathways (LeDoux, 1996) lie in the separate abilities of first having emotion and then regulating emotion (Greenberg & Bolger, 2001).

Damasio (2003) synthesises the pathways. He suggests that the emotion is triggered in the first pathway, via the amydala in the subcortical center, which then activates sensory changes in the hypothalamus, brain stem, and basal forebrain. This activation represents a conscious discrepancy between how the environment is experienced and how it should be experienced, in the right parietal cortex and left cortex. In this sequence, he defines the emotion as the bodily changes (action tendency).

The conscious feeling level is the cortical representation of bodily changes, or emotion recognition (Damasio, 2003). In other words, the emotion chain begins with an emotionally competent stimulus (e.g., bear) in the sensory regions (e.g., visual) which then activates the amygdala, which subsequently activates other sites (e.g., basal forebrain, hypothalamus). Damasio emphasizes the high level of neural integration required in order to associate an original object (e.g., bear) with the emotional response. Whether the emotion chain reaction begins in the cortex or subcortical structure, the process seems automatic. This makes emotions difficult to regulate, especially because emotions have a tendency to amplify when the trigger, real or imagined threat, is not alleviated.

The complexity of the role of the amygdala in the emotional evaluation of stimuli is highlighted in Zald's (2003) review of the neurological research on emotion. Functional neuroimaging and other empirical research provide evidence of important advances in the localization, differentiation, and activation of the amygdala:

1. Multiple sensory modalities are responsible for the activation of the amygdala during exposure to aversive stimuli.
2. These responses are modulated by the arousal levels and motivational value of the stimuli and are easily habituated.
3. Activation and lateralization of the amygdala is influenced by psychiatric status, gender, and personality.
4. Conscious awareness is not necessary for processing in the amygdala.
5. Appraisals are not dependent on the activation of the amygdala.

With bases in the evolutionary perspective, neuroscientists have proposed that emotions are attributes of subcortical and higher limbic activities (Panksepp, 2000). They are processed in the amygdala and hippocampus (LeDoux & Phelps, 2000) as parallel pathways (LeDoux, 1996) and they are understood through learning and memory in the brain. The hypothesis that emotions may be understood through learning and memory in the brain (LeDoux & Phelps) is consistent with an important fact about the brain - that there is no unitary emotional circuit in the brain, only "shared psychoneurological properties of basic emotional systems" (Panksepp, p. 137). This proposition opens the door to understanding the relationship between emotions and learning and memory. According to Lazarus (1991), the learning component of the emotion process, at the cognitive level, begins with an appraisal of some antecedent event, triggering facial expressions, physiological changes, and subjective experience. All new emotional experiences are appraised (Arnold, 1968) probably via LeDoux's second pathway and subsequently only in the first pathway until new information is acquired.

More recently, Anderson, and Green (2001) used a behavioural learning experiment to ascertain subjects' control over suppression of memories. They discovered that consistent attempts to prevent awareness of non-traumatic memories, despite cues, resulted in difficult recall. These results support the existence of an inhibitory control mechanism and support the hypothesis that avoidance of memories resists incentives for recall. Levy and Anderson (2002) further discuss the commonality of neural systems involved in inhibiting and retrieving memories. In their examination of the literature, they synthesise corroboratory, empirical evidence that similar inhibitory mechanisms control overt behaviour and memory retrieval. The application of this research for emotional experiences of being suicidal may only be implied at this point. There may be a relationship between this inhibitory control mechanism and emotion regulation.

The neurological aspects of emotions are difficult to understand, especially because there is no single neurological pathway for emotions. Rather, there are multiple, complex pathways that intertwine with learning and memory and many other brain behaviour functions that influence emotional experiences. The main contribution of the neurological perspective is that emotions are information processing systems.

Cognitive Aspects of Emotion. The cognitive aspects of emotion are conceptualized by Lazarus (1991) in his cognitive-motivational-relational theory.

In this theory, Lazarus' (1984, 1991) writings concur with Frijda (1994b), although Lazarus emphasizes cognitive appraisal,

> Cognitive activity is a necessary precondition of emotion because to experience an emotion, people must comprehend – whether in the form of a primitive evaluative perception or a highly differentiated symbolic process- that their well-being is implicated in a transaction, for better or worse (Lazarus, 1984, p. 124).

In this individualized system theory, emotions are organized according to antecedent, mediating process, and outcome or response. Emotions are based on the process or change principle and on the structure principle, the latter which reflects stable and recurrent emotional patterns within the same person. Lazarus' theory is based on a theme of relational meaning, suggesting that each emotion has a unique meaning that is expressed in a core relational theme according to personal harms and benefits involved in the process of appraisal. As such, this appraisal process parallels Frijda's (1994b) idea that emotions identify matters of concern to the self. This appraisal process consists of decision-making components that have motivational stakes and coping processes.

Lazarus extends this model to psychotherapy. He posits that psychopathology represents failure in coping and appraisal and that therapeutic change involves the integration of cognition, motivation, and emotion. Thus, therapeutic change occurs through a process of emotional insight.

Physiological Aspects of Emotion. William James (1884/1983) contended that sensation precedes emotion and emphasized that emotional states are recognized through physiological sensations, which precede emotional feeling. Using physical danger as an example, one knows she is scared because she sees herself running. Barbalet (1999) asserts that James' theory did not end with the consciousness of the emotional reaction in the body. James' theory includes the consequences of that emotional reaction in thoughts and behaviours even though this component has been historically omitted in James' theory. Barbalet explains that much of this misinterpretation lies in writings isolated to one publication. However, the ideas in *What is an Emotion* (James 1884/1983) do not give due reference to subsequent publications that extend his "theory of emotional consciousness". This extension includes the purposive function of that consciousness on informing actions of the experiencing self, "our various ways of feeling and thinking have grown to be what they are because of their utility in shaping our *reactions* on the outer world" (James, 1892 cited in Barbalet, 1999). Barbalet acknowledged that "James' account of the consequences of emotions on thought and action is extensive, diverse, and highly stimulating" (p. 259). Emotional feelings influence behaviour by "constituting particular dispositions that are associated with particular ways of thinking and acting" (Barbalet, p. 258).

At the physiological level, an emotion cannot be understood without recognizing the emotional experience surrounding an emotion, such as the cognitions and behaviours provoked by the physiological aspects of an emotion. For example, White (2000) conceptualizes emotional experience as "hard-wired, biological affects" and introduces the term *emotional meaning* to represent the interpretive cultural influences on top of feeling states or facial expressions (p. 31). It is the subjective experience of emotions that occurs in consciousness at physiological and cognitive levels and it is this experience of emotion that is of particular interest in this study.

Developmental Aspects of Emotion. Developmental and personality components of emotions also help to understand the context of emotions. Izard and Ackerman (2000) provide a developmental and personality perspective, Differential Emotions Theory, that emphasizes the motivating role of emotions on cognition and behaviour. They posit that motivation, cognition, and behaviour patterns are unique for each individual as a function of maturation and social process that organize into personality traits. This perspective is based on the assumption "that the emotions system constitutes the primary motivational system for human behaviour, and that each discrete emotion serves unique functions in coping and adaptation" (p. 262). Izard and Ackerman assert that these "recurring patterns of interacting emotions play a significant role in behaviour and the development of personality" (p. 262). Direct empirical evidence for this perspective is not yet available.

Integrating Theory. Greenberg's theory of emotion synthesizes the major components of emotion and perspectives of emotion into a comprehensive theory of emotion acknowledging the main areas of agreement by emotion theorists (Frijda, 1986; Greenberg & Paivio, 1997; Lazarus, 1991). The following is an overview of his theory of emotion (Greenberg & Paivio). Greenberg integrates the multiple originating sources of emotion – neurochemical, physiological, biopsychological, evolutionary, and cognitive, while acknowledging the five main components of emotion. First, emotions are adaptive (Darwin, 1872/1955) in order to connect "our biological nature with the world within which it is embedded" (Greenberg & Paivio, p. 15), which is a different world nowadays, with different survival opportunities. Greenberg and Paivio clarify the emotion cognition sequence in the following quote, "Emotion initially preceded cognition in motivating action, but in our present evolutionary stage it is virtually impossible to experience emotion without cognitive functioning" (p. 15). Emotions are seen as consisting of physiological changes, meaning, and action tendencies (Greenberg, Rice, & Elliott, 1993). This dialectical-constructivist view recognizes that emotions are biologically- and evolutionarily- adaptive but that some learning experiences and individual differences may create maladaptive schemes (Greenberg, 2004). Such may be the case when a child is criticised for seeking closeness (Greenberg).

Emotions organize us for action in a goal-oriented fashion (Frijda, 1986), whereby the emotion sets the goal and cognition provides the means to meet the goal. Greenberg and Paivio (1997) implicate the subcortical areas of the brain in this regard (LeDoux, 1993). Emotions influence memory, reason, and decision-making (Greenberg & Paivio). The physiological and action tendency functions of emotion motivate people to deal with events identified by emotions as matters of concern to the person (Greenberg & Paivio). Emotions, then, are information systems to the person and also to others when emotions are expressed, as in the case of an infant crying (Greenberg & Paivio).

The main contribution of Greenberg's (2002) theory of emotion is his thoughts about the regulation of emotions (Greenberg & Bolger, 2001) and the important contribution of emotion in living wisely. Emotion regulation involves a process of learning the symbolization of a pattern of neurochemical affective processes, physiological arousal, and expressive-motor processes, usually in the context of a relationship with an attachment figure, into a relatively more mature balance of experience and expression throughout the developmental process (Greenberg & Paivio, 1997). It is a process of recognizing and translating emotions into applicable messages and action. Emotions function as indispensable ways of accessing one's needs and wants.

There is a primary and secondary feature of emotions with the former attesting to biological affects and the latter attesting to cultural or cognitive processes (White, 2000). For example, Greenberg and Bolger (2001) categorize primary emotions as fundamental and genuine feelings and original reactions. Some examples include sadness, fear, joy, and anger. Secondary emotions are responses to primary emotions, such as in the case of feeling angry in response to feeling hurt. Korman and Greenberg (1996) add a third category comprised of instrumental emotions, which involve a degree of manipulation, such as with feelings of inadequacy and helplessness. Emotions are maladaptive (e.g., shame, abandonment) if they do not transform when expressed or contribute to problem solving efforts (Greenberg & Bolger). The emotion sequence, as described by Greenberg (2002), consists of the activation of an emotion scheme by causing a conscious awareness of emotion and need, cognition, and an action tendency, which then leads to behaviour.

Emotional Intelligence. Emotional intelligence is an important concept to grasp in the emotion literature, especially in light of the complexity of emotion in the context of learning and memory, evolutionary, biological, developmental, and neurological thought on emotion. Emotional intelligence has been described as the

> ability to perceive emotions, to access and generate emotions so as to assist thought, to understand emotions and emotional knowledge, and to reflectively regulate emotion so as to promote emotional and intellectual growth (Mayer & Salovey, 1997, p. 5).

Mayer, Caruso, and Salovey (1999) propose a hierarchical, four level mental ability model of emotional intelligence. The first level involves the ability to appraise verbal and nonverbal emotion and express emotions. The second level involves the ability to use emotion to facilitate thoughts and behaviours. The third level involves the ability to understand and reason about emotions. The last and highest level involves the developing ability to manage and regulate emotion in oneself and others.

Similarly, Greenberg (2002) describes emotional intelligence as an integration of rationale and emotional streams of consciousness by an awareness, reflection, and regulation of emotional experience. Woolfolk (1998) emphasizes the influence of values on emotions, and, in fact, states that the two are "inseparable" (p. 117). He postulates that psychotherapy is a form of education, a process of developing emotional intelligence.

Within the context of emotional intelligence, metaemotional processing involves identifying, labelling, describing, remembering emotions, reasoning, analyzing, and empathizing emotional experiences (Lundh, Johnsson, Sundqvi, & Olsson, 2002). Closely related to this metaemotional processing is the construct, *alexithymia*, which is defined as difficulty identifying and describing emotions (Lundh et al.). Empirical attention to alexithymia has become an interdisciplinary concern with respect to research on its measurement, processing, and developmental aspects (Taylor & Bagby, 2004). For example, alexithymia has been found to correlate positively with perfectionism but not with memory of emotion or emotional awareness (Lundh et al.). These results are puzzling given the logical expectation that emotion awareness and emotion memory inversely correlate with alexithymia.

Emotion regulation and emotional intelligence are closely related terms. Emotional intelligence allows a person to manage and regulate emotions, adaptively or maladaptively. As such, the inclusion of measurement of emotional intelligence in psychotherapy may be an important advancement in psychotherapy. Ongoing measurements and the feedback to the patient and therapist could act as a motivational strategy and as a progress indicator. So far, attempts at constructing such measuring devises are preliminary (e.g., Mayer et al., 1999; Roberts, Zeidner, & Matthews, 2001).

Emotional intelligence and especially emotion regulation have been associated with coping skills. For example, Moskowitz (2001) discusses emotional coping in the context of chronic stress. She argues that positive emotions buffer stress and so psychotherapy may focus on increasing positive emotions in addition to decreasing negative emotions. There is no doubt that ability to cope with difficult emotions has much individual variability with respect to coping thresholds and experience with stress. Lazarus (1991) identifies two types of coping that have relevance to this review: problem-focused coping, which produces actual change in the person-environment relationship, and emotion-focused coping versus cognitive coping, both of which change only the way a relationship is perceived or attended to.

Thus, emotions may be understood from multiple lenses that complement, rather than contradict one another. All theorists seem to agree that emotions have informing, motivating, and organizing functions (Frijda, 1986; Lazarus, 1991; Greenberg, 1993). They provide an important service – they function as radar that screens information of concern to the self. The abilities of emotions do not stop when important stimulus has been recognized. Emotions also have a motivating agent, preparing and organizing one to respond to the matter of concern. Emotions are fundamentally adaptive, information processing systems that identify matters of concern and prepare a person for taking action, by coordinating and directing experience.

Emotions and Empirical Research in Psychotherapy

Emotions and Psychotherapeutic Change. Psychotherapy is "training of the emotions" (Perls et al. 1951, p. 99). Psychotherapy was described by Strupp (1978) as "an interpersonal process designed to bring about modifications of feelings, cognitions, attitudes, and behaviours which have proved troublesome to the person seeking help from a trained professional" (p. 3). In their roles as informing and motivating agents, distressing emotions guide people to psychotherapy. Psychotherapy is a process of learning how to regulate emotions by integrating the rational stream of consciousness with the emotional stream of consciousness towards emotional intelligence (Greenberg, 2002). As such, therapists find themselves *coaching* clients in a collaborative and exploratory process that facilitates awareness of one's emotions and then learning to regulate those emotions in a more adaptive manner (Greenberg & Bolger, 2001).

Despite the recognition of the importance of emotion, there has been an absence of a comprehensive theoretical treatment of emotion in psychotherapy until recently (Greenberg & Paivio, 1997). Traditional perspectives include those focused on emotional insight, such as in humanistic and experiential perspectives, those focused on discharge, such as the psychoanalytic perspective, those focused on thought processes, such as the cognitive perspective, and those focused on exposure, such as in the behavioural perspectives (Greenberg & Safran, 1987). The following is a differentiation of the major psychotherapeutic orientations with respect to their approach to emotions in psychotherapy.

Emotions in the Humanistic and Experiential Tradition. The Humanistic and Existential tradition (Perls et al., 1951; Rogers, 1957) views emotions as having a more active and necessary role in therapeutic change than do the Psychodynamic and Cognitive Behavioural traditions. The humanistic and experiential tradition is discovery-oriented. Clients are considered the experts of their own experiences. They are encouraged to become aware of, symbolize, and develop their ongoing inner experiences (Greenberg et al., 1993). These fundamental experiences are seen to impact on motivation towards growth and development. This emphasizes moment-by-moment experiencing, which is an emotional experience. Although attention to emotions is paramount in the humanistic and experiential tradition, specific references to the emotional process are difficult to delineate. The therapeutic relationship is also central to the humanistic and experiential tradition. Major contributors to the humanistic and experiential tradition are Yalom, Perls, May, Rogers, and Greenberg.

Of the humanistic approaches to psychotherapy, Perls contributed the most about emotion. Perls' Gestalt approach to psychotherapy (1973) emphasizes the premise that human nature can be "understood as a function of the patterns or wholes of which it is made" (p. 4) and the premise that an individual satisfies needs through interaction with the environment. People become maladjusted when they do not use their abilities for self-regulation and instead spend energy on acting helpless or leaning on others. The intention of psychotherapy is to foster awareness so that those parts can be integrated through sensation, experiencing, and feeling. According to Perls and his colleagues,

> Experiencing the organism/environment field *under the aspect of value* is what constitutes *emotion* ...Emotion is a *continuous* process, since every instant of ones life carries in some degree a feeling – tone of pleasantness or unpleasantness...However, because in modern man this continuity of emotional experience is, for the most part, suppressed from awareness, emotion is regarded as a kind of periodic upheaval, which occurs unaccountably in one's behaviour on those very occasions when one would most like to "exercise control". Such eruptions – which are so "unreasonable"! – tend, of course, to be dreaded and guarded against. Whenever possible, one endeavors to stay out of situations which might bring them about (Perls et al., 1951, p. 95).

Furthermore,

> emotion, considered as the organism's direct evaluative experience of the organism/environment field, is not mediated by thoughts and verbal judgments, but is *im*mediate. As such, it is a crucial regulator of action, for it not only furnishes the basis of awareness of what is important but it also energizes appropriate action, or, if this is not at once available, it energizes and directs the search for it (Perls et al., 1951, p. 95).

This awareness component of emotions plays a particularly important part in the gestalt approach:

> It is only in the recognition of your emotions that you can be aware, as a biological organism, either of what you are up against in the environment or of what special opportunities are at the moment presented. It is only if you acknowledge and accept your longing for someone or something – the assessment of the strength of your urge to seek out this person or thing as you confront the distance or obstacles that separate you – that you obtain orientation for appropriate action. It is only if you acknowledge and accept your grief ...that you can weep and say good-bye (Perls et al.,

1951, 98-99).

The gestalt approach, then, emphasizes the ongoing, evaluative experiencing aspects of emotion. This awareness component helps to prepare and motivate the individual for action.

Greenberg builds heavily on the gestalt approach in his application of emotion to psychotherapy. He comprehensively bridged a theoretical approach of emotions to psychotherapy. In this approach, Greenberg emphasizes the informing function of emotion in his integration of experiential, biological and evolutionary theories of emotion (Greenberg & Paivio, 1997), as discussed earlier. This information is adaptive for the most part in that it assesses needs and wants in order to be able to act, which is consistent with both Perls' et al. (1951) and Rogers' (1957) thought on emotion. The idea, here, is that we need to recognize our emotions in order to manage them to influence our decisions (Greenberg & Paivio, 1997).

Emotions have a "natural process of emergence and completion" (Greenberg & Paivio, 1997, p. 26). Given that emotions happen automatically, depending on what one is exposed to and attends to, learning to accept emotions and learning from emotions comes from becoming aware of those emotions, owning them, and expressing them (Greenberg & Paivio). Both Greenberg (Greenberg & Paivio) and Linehan (1993) advocate taking a step back to allow emotions to come and go in order to benefit from this learning process. Greenberg's application of theory to psychotherapy also emphasizes the need to regulate emotions. Overall, emotions are guides to living wisely. The cognitive component in this theory is termed *emotional intelligence* (Paivio & Greenberg, 1998).

Emotion-focused Therapy (EFT: Greenberg, 2002) is an empirically-based (see Elliott, Watson, Goldman, & Greenberg, 2004), integrative approach to psychotherapy with client-centered, gestalt, and cognitive principles, that focuses on changing emotions. EFT was developed by Leslie Greenberg. In EFT, emotions guide the construction and organization of the self (Greenberg, 2004). Cognition and behaviour are dependent on emotion in this approach. It is consistent with Rogers' (1957) inclination that one needs to become aware of emotions in order to know what one needs or wants to be able to act. Within the context of an "empathically attuned affect regulating relationship" (Greenberg as cited in Sloan, 2004), clients are coached through a process of emotion awareness, emotion regulation, and emotion transformation.

With emphasis on restructuring experiences, EFT interventions involve synthesising, evoking, and restructuring emotions, and accessing state-dependent core beliefs emerging from emotional experiences (Greenberg & Safran, 1989). Emotion-focused therapy is based on the premise that emotions are the basic foundation of self-organization and the construction of the self (Greenberg, 2004). The treatment process (Greenberg & Paivio, 1997) begins with establishing a therapeutic alliance with the client. The second phase deals with acknowledging and regulating the intensity of emotions through evoking and exploring or overcoming the avoidance of specific emotions. This phase involves expressing the emotion, if it is adaptive to do so, in order to access the primary emotion (Greenberg & Bolger, 2001). Finally, the third phase deals with restructuring emotion schemes by challenging beliefs and creating adaptive schemes by constructing new emotional experiences (Greenberg & Bolger) through reflection and perspective building.

Greenberg (2004) identifies the following principles of change in EFT: emotion awareness, emotion assessment, emotion regulation, and emotion transformation or changing emotion with emotion. Transforming maladaptive feelings and beliefs is assisted with shifting attention to a background or subdominant feeling, assessing needs and goals, positive imagery, expressing the emotion, remembering another emotion, cognitively creating new meaning, therapist expression of the emotion, and evoking new emotion (Greenberg, 2002).

One form of EFT is process-experiential psychotherapy (Greenberg et al., 1993), which is aimed towards developing emotional intelligence (Mayer, Salovey, & Caruso, 2004). Process-experiential psychotherapy is an empirically supported (Elliott & Greenberg, 2002; Elliott, Greenberg, & Lietaer, 2003), humanistic treatment, integrating person-centered, gestalt, and existential therapies. Another form of EFT is the dialectical-constructivist view that a person creates new meaning from a process of symbolizing bodily-felt experiences (Greenberg et al., 1993; Greenberg & Pascual-Leone, 2001). In this view,

> attending to, and discovery of, pre-conceptual, elements of experience, influences the process of meaning construction while the process of meaning construction influences what is experience (Greenberg, 2004, p. 5).

In other words, meaning construction and what one attends to influence one another.

Yalom (2002) suggests that psychotherapy is an "alternating sequence of affect expression and affect analysis" (p. 164) with respect to the meaning of the emotions as well as the experience of expressing emotions in session. In the context of group therapy Yalom (1998) suggests that therapeutic change occurs in a complex process through the interplay of eleven human experiences, which he defined as "therapeutic factors" (p. 7). These factors include hope, universality, information about mental health, mental illness and psychodynamics, altruism, corrective group therapy resembling a family, socializing factors, group cohesiveness, interpersonal learning, and catharsis. He emphasizes the interplay of catharsis with the other therapeutic factors, linking effective catharsis to the development of cohesiveness in the context of genuine attempts to learn within the group.

May's (1989) psychotherapy evolved from his theory of the human personality as an "actualization of the life process in a free individual who is socially integrated and is aware of spirit" (p. 14). May said that the key to the counselling process is empathy. With specific reference to emotion, he emphasized the fostering of emotional equilibrium via empathy in the counselling session. He acknowledged that it may be advisable for a client to release tension but he encourages a return to emotional equilibrium.

Rogers pioneered the person-centred approach within which he emphasizes awareness, acceptance, experiencing, and understanding of feelings through a trusting, empathic therapist-client relationship. Rogers' (1957) therapeutic triad consists of three "necessary and sufficient conditions for growth and change in personality": congruence, unconditional positive regard, and accurate empathic understanding. In this context of therapeutic conditions, Rogers emphasizes fostering affect and self-actualization. This approach focuses on clients' responsibility and capacity to discover more appropriate behaviours based on a developing self-awareness. Maladaptive behaviour is attributed to incongruence between the real and the ideal self. The therapist's role in this approach is to help the client to fully experience her feelings so that she can move along the process of change (Rogers, 1986). Rogers (1957) emphasizes the effect of interpersonal encounters, as in the emotions of shame and jealousy, on a person's sense of self.

Humanistic Research on Emotions in Psychotherapy. The importance of emotions in therapeutic change in humanistic and experiential research has been gaining empirical ground (Watson, Greenberg, & Lietaer, 1998). Their relevance has primarily emerged from investigations of psychotherapy process and they have also been the direct focus of inquiry.

Direct inquiries on emotions in humanistic and experiential therapy include Bolger's (1999) exploration of the process of emotional pain. Bolger recruited seven middle-aged women. These women were adult children of alcoholics participating in group therapy for the resolution of emotional pain. Bolger acted as a participant observer in the group session and conducted a grounded theory analysis of post-session interviews immediately following the group, and at six-month follow-up. Bolger discovered that the essence of emotional pain is a feeling and awareness of *brokenness* or a shattering of the self. The process moved from hiding painful experiences from awareness to re-experiencing traumatic events by remembering and talking. This re-experiencing of pain led to a transformed and restructured self. Despite the focus on the initial six months of intervention and the small sample size, these results provide a useful framework for understanding the complexity of the emotional process. The findings mirror Rogers' (1957) notion of incongruence between the real self and the ideal self, thereby offering a perspective into the process of having a healthier self.

More recently, Stuart (2002) investigated clients' emotional experiences and perception of helpful aspects of that experience in counselling using a combined interview and concept mapping approach. This method of multidimensional scaling and hierarchical cluster analysis generated the following regional thematic clusters from the sorting task: *Understanding My Emotions, Volatility, Avoidance, Negative Influence of Emotions, Dealing with Emotions, Resolving Emotions, Integration*, and *Connecting to Self.* For this research, the most important finding was that "participants experience emotion in psychotherapy as a part of a process" (p. 120). Analysis identified the following components in the process: *Breakdown of Coping Strategies, Increased Emotional Awareness*, and *Reorganization* of the emotional experience.

The relationship between emotional experiencing and therapeutic change and outcome has been demonstrated from the humanistic focus on *experiencing* and depth of experiencing (Gendlin, 1996; Klein et al., 1986; Orlinsky & Howard, 1978; Rogers, 1957). Empirical evidence of the value of emotional experiencing in humanistic and experiential therapies has been measured with the Experiencing Scale, an observer-rated scale ranging from an emotionless account of one's experience to an integrated account that prepares one to form new meaning (Klein et al.). Research using the Experiencing Scales (Klein et al.) provides evidence of the relationship between experiencing and outcome in psychotherapy (Greenberg & Safran, 1987). Other instruments include The Client Vocal Quality System (CVQ system: Rice, Koke, Greenberg, & Wagstaff, 1979), which measures the affective-cognitive processes of the client throughout the session, and the Wimbledon Self-Report Scale, which measures mood appraisal (Coughlan, 1988).

Emotion episodes (EE) are foci of research in experiential psychotherapy (Greenberg & Korman, 1993). Emotion episodes are sections of transcribed therapy sessions, which include the basic components of an emotion, such as the situation, the emotion, the appraisal and the personal concern. Positive therapeutic outcome has been correlated with changes in emotional states from early to late therapy with this method (Korman, 1998).

Emotional processing has been identified as a type of emotional experiencing whereby emotional events are processed if they are potentially available to consciousness (Pos, Greenberg, Goldman, & Korman, 2003). Deeper emotional processing was examined in a study of EEs in client centred and process experiential treatments for depression. Using several self-report measures, Pos et al. were able to conclude that emotional-processing abilities significantly improved throughout treatment and deeper processing was correlated to decreases in symptomology and increases in self-esteem, but not with improvement in interpersonal problems.

Emotional processes have been researched in group, couple, and interpersonal therapy. The relationship between degree of emotional arousal and outcome, when compared with psychoeducational groups has been demonstrated in a study of unfinished business using the empty-chair dialogue (Paivio & Greenberg, 1995). Further empirical attention to unfinished business dialogues has demonstrated a significant relationship between emotional arousal and depth of emotional processing to the expression of needs and shift in self-other schemas in differentiating those who resolved and those who did not resolve (Greenberg & Malcolm, 2002).

Using interpersonal process recall (IPR) interviews, Greenberg and Paivio (1998) sought to provide evidence for their process-diagnostic approach to evaluating emotional experience in psychotherapy. Clients were asked to view videotapes of their sessions and recall their internal experiences regarding important moments. Their qualitative accounts provided evidence for the model and include the following categories of emotional experience: avoidance, allowing, owning, interruptive belief, relief, and self-affirmation.

The importance of emotions in therapeutic change has also emerged from indirect empirical attention to the broader psychotherapy experience. Paulson, Truscott, and Stuart (1999) identified emotional relief as a helpful aspect of psychotherapy. This study used actual psychotherapy clients, thereby increasing the validity of the results as applicable to work in psychotherapy. Their Emotional Relief cluster has great applicability to this study. It consists of emotional expression and relief as agents of helpfulness in resolving emotions. Its identification as a helpful element in psychotherapy provides a basis from which to further explore the experience of emotions in general and emotional relief in particular.

Other indirect inquiry of emotions in studies of the client's broader psychotherapy experience include Rennie's (1992) application of grounded theory method to the clients moment-by-moment experiences of an hour of psychotherapy. The core category became known as *client's reflexivity* and encompasses self-awareness and agency that emerged from the categories. The first category depicts the client's contact with feeling and catharsis. This category encompasses the client's relationship with personal meaning, which involved the pursuit and avoidance of meaning. Other categories include the client's perception of the relationship with the therapist, the client's experience of the therapists operations and the client's experience of outcomes. However, the focus on one hour of psychotherapy does not allow insight into client's overall process of change.

Together, these findings highlight the organizing value of emotions in experiential therapy, in working through fear, anxiety, and meaninglessness, to name a few therapeutic themes. Humanistic and experiential therapies aim to reinforce and validate immediate experience and view emotional problems as arising from life events that inhibit a person from his or her self-actualizing potential (Roth & Fonagy, 1996). In this respect, humanistic and experiential therapies focus on awareness of emotional experiences and the client's responsibility to translate that awareness into meaning. Research has implicated emotional expression and relief as helpful in resolving emotions in studies accessing the broader psychotherapy experience (Paulson et al., 1999). More direct inquiry of emotional experiences has identified a process of emotional pain in the context of brokenness of the self (Bolger, 1999) and has identified the emotional process of psychotherapy (Stuart, 2002). Direct studies of emotions in psychotherapy also demonstrate the utility of emotional experiencing in favourable psychotherapy outcome (Greenberg & Safran, 1987).

Emotions in the Cognitive and Behavioural Traditions. The Behavioural tradition contributes an understanding of emotional processing to the emotion literature. Rachman (1980) defines emotional processing as "a process whereby emotional disturbances are absorbed, and decline to the extent that other experiences and behaviour can proceed without disruption" (p. 51). Such processing may be successful or unsuccessful, the latter of which translates into "intrusive signs of emotional activity" (p. 51), such as inability to concentrate, restlessness, irritability, obsessiveness, nightmares, phobias, or inappropriate expressions of emotion. These intrusive signs appear when emotional disturbances are not absorbed satisfactorily, in a reasonable amount of time. Among the factors that impede emotional processing include avoidance, fatigue, distractions, and irregularity of exposures. Continuing with Rachman's thoughts, emotional processing is successful when behaviour is not interrupted following an emotional disturbance. For example, effective fear-reduction techniques emphasize repeated exposure to the feared stimuli in order to absorb disruptive emotional reactions. Among the factors that promote successful emotional processing include catharsis, exposure, habituation training, and relaxation.

Cognitive arousal theorists emphasize the influence of physical arousal on the intensity of the emotion and the influence of cognition on ascertaining the quality of the emotion (Leventhal & Tomarken, 1986). Cognitive appraisal theorists view emotions as developing from our memory of past experiences and a degree of empathy and imagination (Arnold, 1968). Other cognitive theorists (e.g., Lazarus, 1991, 1984) stress cultural and learning factors in their conceptualization of emotional experience.

Although older cognitive models assume the primacy of cognition in the emotional process, more recent models emphasize the independence of cognition, behaviour, and physiological experience (LeDoux, 1996; Greenberg & Safran, 1990; Plutchik, 1994; Zajonc, 1984). However, some cognitive neuroscientists (Lane, Nadel, Allen, & Kaszniak, 2000) argue that emotion and cognition cannot be studied separately due to potentially overlapping response systems.

Beck's (1976) original cognitive therapy model represents a process whereby schemes produce negative automatic thoughts, which subsequently influence emotion. More recently, Power and Schmidt (2004) propose a multilevel approach to cognitive therapy (SPAARS). In this model, initial processing in the sensory systems informs three parallel representational systems. The schematic level represents appraisal, the propositional level includes thought about future emotion-laden episodes, and the associative level represents automatic emotional reactions, suggesting two different routes to emotion. For example, certain words or phrases may feed through the schematic level and the associative level. Power and Schmidt suggest that emotion disorders result from the coupling of two or more basic emotions through this process.

More recent thought on cognitive approaches to psychotherapy acknowledges the alliance of emotion and cognition in psychotherapy (Bennett-Levy, 2003; Coombs, Coleman, & Jones, 2002; Holland, 2003; Leahy, 2003). For example, Bennett-Levy (2003) examined the different cognitive subsystems in thought records versus behavioural experiments in cognitive therapy. Using qualitative accounts and questionnaires by clients, he identified different modes of processing, with behavioural experiments having extensive links with emotion, with respect to behaviour and belief change. Further, the inception of narrative constructions of cognitive behaviour modification is explained in Meichenbaum's (1993) use of metaphors to explain client thought processes. Meichenbaum states that emotional distress "is viewed as a normal spontaneous reconstructive and natural rehabilitative adaptive process" (p. 204). His movement of the spotlight from treating pathology to building problem and coping skills with meaning-making strategies represents a different cognitive lens from which to view the treatment process.

Despite the empirical grounding of cognitive behavioural therapy (CBT), it has problems. Leahy (2003) highlights the importance of emotions in cognitive therapy in his consideration of the challenges and opportunities of change in evidence-based interventions. With respect to emotions, Leahy (2003) recognizes that CBT theorists have not historically acknowledged the importance of emotions in therapeutic change. He appreciates that people come to psychotherapy to relieve emotional distress as opposed to change distorted thoughts, and he offers a model of emotional schemas. Leahy's model emphasizes the universality of unpleasant emotions, and individual variability in interpretation of emotion, which reflect beliefs about the emotions and the self, which are then further exacerbated by negative emotion schemas. These emotion schemas influence expression, validation, and emotional processing. According to Leahy's model there are three pathways for an unpleasant emotion to take. First, the person attends to the emotion but lacks the ability to normalise, express, and validate the emotion. Secondly, emotions and their cognitive associations are avoided by bingeing, drinking, or dissociation. Thirdly, emotions are viewed as incomprehensible and shameful. Both the second and third pathways inevitably lead to worry and rumination and general escalation of negative feelings.

Leahy (2003) further encourages an examination of the client's earlier social environment with respect to how parents respond to and express feelings in relation to how their current environment generally expressed and responds to feelings. This examination addresses fears of self-disclosure and fears of accessing and describing feelings. Interventions and strategies useful in evaluating emotional schemas include introducing a process of comprehending emotion, challenging simplistic views of emotion, challenging guilt for having emotions, challenging the belief that emotion must be extinguished, normalizing emotions, addressing the purpose of rumination, and exploring the potential acceptance of an emotion. These interventions foster awareness and facilitate the shift from problematic coping to positive coping thereby facilitating a reduction in symptoms. This combination of CB techniques and metacognitve use of emotional schemas represents a growing interest in the inclusion of emotion-related processing beyond the traditional attention to schemas and subsequent exposure experiments.

Holland (2003) also recognizes that reducing negative emotions without learning to tolerate them, thereby leading to avoidance of emotion, maintains symptoms. This avoidance makes it difficult to target maladaptive thoughts and schemas, and prevents clients from benefiting from the adaptive features of emotion (information, communication, and motivation). The avoidance behaviours, such as compulsive rituals and avoidance of situations, create more suffering. Holland encourages CB therapists and other practitioners to help the patient to identify the avoidance of emotion and explore the triggers, functions, and consequences of that avoidance. Then, traditional cognitive techniques may be used to modify maladaptive beliefs and assumptions about emotions, enhance coping skills, use response prevention techniques for coping with negative emotions, and exposure methods to expose one to the emotion and the thoughts and situations that trigger them. Emotions can be targeted in these methods given that they are based on a realistic appraisal of the trigger. Both Holland (2003) and Leahy (2003) emphasize the importance of attributing a greater role to emotions in therapeutic change using CBT and this line of thought represents an advance in CB therapies, representing an overall recognition of the value of emotional processing and emotional experiences.

Cognitive and Behavioural Research on Emotions in Psychotherapy. Rather than viewing emotions as disruptive, more contemporary research on emotion in cognitive therapy acknowledges the usefulness of allowing and accepting painful emotions (e.g., Blackledge & Hayes, 2001; Leahy, 2002). Empirical evidence for the effectiveness of cognitive therapy is abundant, partly due to the feasibility with which cognitive therapy may be researched. For instance, cognitive therapy utilizes ongoing tracking of symptoms as part of the method of psychotherapy, which makes it easier to quantify in a research study.

The distinction between cognitive and behavioural interventions may best be understood on a continuum, depending on the orientation of the clinician (Roth & Fonagy, 1996). Both cognitive and behavioural theories treat emotions implicitly but from the perspective of learned responses. However, cognitive therapies focus on irrational cognitive processes whereas behavioural therapies focus on observable behaviours. Cognitive-behavioural therapies represent the middle of the continuum in their attention to the degree of influence of thoughts and beliefs on behaviour (Roth & Fonagy) and conceptualize emotions as occurring after the thought (Greenberg & Safran, 1987). Both have traditionally placed emotions as responses to the thoughts and beliefs although more recent models have admitted to this oversimplification (Roth & Fonagy). The main contribution of cognitive and behavioural psychotherapy is the identification of the influence of assumptions and beliefs on emotions and vice versa.

For instance, Teasdale et al. (2002) conducted research on a Mindfulness-Based cognitive therapy of depression based on awareness of internal processes and desensitizing emotions by accepting them as normal. His study demonstrated that this approach is effective in preventing relapse in clients with depression. Leahy (2002) followed suit by demonstrating empirical support for his cognitive model of emotional schemas. He differentiated emotional schemas from Greenberg's (2002) use of emotion schemas in EFT by defining them as cognitive structures, as opposed to emotional structures, that guide interpretation and subsequent coping skills. He endorsed two approaches to emotion, the first corroborates Teasdale's et al. (2002) perspective on accepting and normalizing emotional experiences, and the second acknowledging pathological emotional experiences, such as those fostering avoidance, guilt and rumination. In a study of emotional schemas, data collection on the Leahy Emotional Schemas Scale (LESS) along with Beck Anxiety Inventory and the Beck Depression Inventory with outpatients provided support for the role of acceptance and validation of emotion in relieving guilt and rumination. This study also highlighted the necessary complex processing of emotion in the treatment of affective disorders.

There is no shortage of support, such as in these findings, for existing cognitive treatment models for affective disorders. The recent acknowledgement of the importance of emotion in the therapeutic process is especially apparent in matters of emotion regulation, such as in treating self-destructive behaviours and addictions (Linehan, 1993). Linehan's cognitive behavioural approach to psychotherapy incorporates emotional validation and self-soothing with empathy in a psychoeducational framework. Emotion regulation is emerging as a framework for understanding many other disorders as well (Mennin, Heimberg, Turk, & Fresco, 2002). In this respect, cognitive therapies have common ground with humanistic and existential therapies with respect to being empirically-validated treatments.

Behaviour therapy focuses on exposure and counter conditioning in which an undesired state is replaced with an incompatible state (Wolpe, 1982). The relationship between emotional experiencing and therapeutic change from a behavioural perspective is demonstrated in the behavioural focus on "emotional processing". Solid empirical support for behaviour therapy through emotional processing has been documented in numerous studies. These studies attest to the requirement of an activated emotional state necessary for successful restructuring (e.g., Foa, Riggs, Massie & Yarczower, 1995; Foa, Rothbaum, & Furr, 2003) with specific attention to the emotional processing of fear and anxiety (Hunt, 1998). For example, a review of the studies on the efficacy of exposure therapy and other interventions for post-traumatic stress disorder (PTSD), Foa et al. (2003) found that exposure therapy, involving both core components (imaginal and in vivo exposure) is effective in reducing PTSD symptom severity, with no demonstrated benefits of adding stress inoculation training or cognitive therapy. Foa and Kosak (1986) examined literature on the mechanism involved in the emotional processing of fear. They conceptualize emotional processing as the modification of memory structures. This processing is indicated by exposure sessions involving physiological activation and habituation. They propose that the elements involved in the emotional processing of a fear structure include cognitive representation of the feared stimulus, the individual's responses to it, and factors concerning the meaning of that response to the individual. These findings provide further evidence that emotional processing is necessary for change, via activation of fear and reduction of fear by exposure. Subsequent research provides additional support for aspects of emotional processing in therapeutic change.

Emotions in the Psychodynamic Tradition. Around the same time that William James (1884/1983) bridged the philosophy and psychology of emotions, Freud (1910) proposed a physics-based mechanistic theory of emotions based on unconscious instincts and psychic and libidinal energies. Both theorists viewed emotions as consequences of situations happening internally or externally. Freud's colleague, Jung (1928) proposed a theory of emotions from the perspective of distinct psychic functions (sensing, intuiting, thinking and feeling). Artz (1994) solidified the distinction between feeling and emotion in Jung's framework. She stated that emotion is the outcome of the feeling or making of value judgements. In this sense, the framework involved personality assessment of the impact of these four functions, rather than attention to one's on-going experience.

Traditionally, psychoanalysis focused on restructuring the entire personality through conscious insight, instinctual impulses, and the presence of a rather passive therapist. As such, attention to emotions is not explicit in psychodynamic psychotherapy. The term *affect* is frequently used in psychodynamic theories (Spezzano, 1993) to describe physical sensation. Freud

(1910) used affect as a means to distinguish hysteria from non-hysteria. He conceptualized emotions as psychic energies and discharge processes. As psychoanalysis evolved into a more active and tolerable examination of a client's "feelings, desires, and beliefs in conflict", emphasis was placed on the functional nature of catharsis (Roth & Fonagy, 1996, p. 5).

Psychodynamic theory, attachment theory, and object relations theory comprise the influence of early attachments and early childhood experiences to the development of emotional adjustment. Bowlby (1988) offers a trilogy of attachment, separation, and loss, in his conviction of a biologically based system of attachment. This system is instrumental to our understanding of emotions and attachment. In fact, Bowlby said that some of the most important emotions are rooted in attachment-related events, such as the formation and ending of relationships and the role of attachment figures in the development of emotional regulation in young children.

Ainsworth's (1967) research on attachment and separation behaviour is also instrumental in understanding the development of attachment disorders and related dispositions to emotion disregulation. Specifically, sensitive behaviour and attachment quality with an attachment figure in the first year can influence emotional experiences in subsequent relationships. Psychoanalysis, as it is based on attachment theory, is associated with behavioural-motivational systems, and it consists of creating a secure base for the person to work through emotional conflicts involving drive dynamics (Brisch, 2002).

The psychoanalytic perspective on emotion is best described by Sandler and Sandler's (1978) thoughts on affect and object relations. Affect, and object relations, in particular are a subjective experience of conscious or unconscious feeling states that may be pleasurable or unpleasurable. Painful feelings, such as lack of affirmation associated with an absent object, can mobilize a wish, such as a wished for interaction that preserves ones safety and pleasant feelings. Feeling and meaning are intimately related in this interaction:

> The assumption is made that ultimately all meaning is developmentally and functionally related to states of feeling, and that an experience which does not have some relation to a feeling-state has no psychological significance for the individual at all (Sandler & Sandler, p. 292).

Psychodynamic Research on Emotion in Psychotherapy. Empirical research on emotion in psychodynamic therapy is not as plentiful as research on cognitive behavioural therapy. Historically, studies of psychodynamic approaches to emotion process in psychotherapy have focused on intense single case analysis. This trend continues in Lecours, Bouchard, St. Amand, and Perry's (2000) analysis of their Verbal Elaboration of Affect Scale (GEVA in French) over 14 sessions of one case. This scale measures affect expression and affect tolerance and abstraction. Preliminary results suggest that positive affects are more frequently mentalized and easier to tolerate and express than painful affects.

Facial affect has been studied in relation to emotional experience, beliefs, psychotherapy outcome and perceptions of same in an unsuccessful psychotherapy in a client therapist dyad with a focus on automatic emotional exchange pattern developed from early life interactions (Dreher, Mengele, Krause, & Krammerer, 2001). Findings indicated a large inconsistency between facial expressions of affect and conscious feelings and frequent displays of expressions suggesting conflict and masking in the client.

Kuhn and McCullough (2002) emphasize the avoidance- and fear- based defences of dynamic conflicts in psychodynamic therapy, thereby highlighting the movement beyond drive forces. The clinical utility of experiential/ psychodynamic psychotherapy is one example of the more contemporary use of the therapeutic relationship to regulate affect. These advances in theoretical thought represent the acknowledgement of emotion in psychodynamic therapy.

Other approaches to emotion in psychodynamic research have focused on the use of language in session. For example, Anderson, Bein, Pinnell, and Strupp (1999) used lexical software to examine the therapist's use of language in good and poor outcome cases. Predictably, therapists have a more efficient and differentiated form of speech. Interestingly, results identified the use of more cognitive verbs in high affect parts of a session in poor outcome cases, giving the impression that it is helpful for attention to be directed away from the emotion experience. Alternatively, this occurrence is possibly a regulating experience, depending on the available skills of the client.

Regarding specific emotion events, MacKay, Barkham, and Stiles (1998) used raters' recordings of audio taped sessions and the clients' account of the impact and helpfulness of the session to assess an anger event in Psychodynamic-interpersonal (PI) therapy. Findings indicated that the client identified the expression of her anger as helpful. Interestingly, as the anger was re-experienced, it changed to a pattern of arousal and pleasure via a process of reorganizing the experience.

Other current process research on emotion in psychodynamic therapy includes a narrative analysis of emotional aspects of clients' stories (Fundamental, Repetitive and Maladaptive Emotion Structure [FRAMES], Dahl & Teller, 1994; Siegel, Sammons, & Dahl, 2002). So far this research has contributed a methodology to be used in future process research on emotion in psychodynamic therapies.

Empirical Comparison of Psychotherapeutic Approaches to Emotion

Although none of the major therapies discussed has consistently demonstrated superior effectiveness on most outcome measures, there are undeniable differences in psychotherapy process with respect to emotions. In a comparison study of CBT and PI therapy using tape-recorded single sessions, Mackay, Barkham, Stiles, and Goldfried (2002) found CBT sessions to be educational and encouraging. The PI sessions were found to be relatively more exploratory and potentially emotionally painful. These results suggest the activation of different emotional mechanisms for the therapies. The same therapies were compared with respect to therapist reaction to client emotion across multiple sessions. Results showed similar differentiation between the therapies: IPT sessions involved a collaborative and exploratory approach, whereas CBT involved an educative/directive approach. A positive relationship was found between collaboration and outcome in both therapies.

In another comparison of approaches, McQueeney, Stanton, and Sigmon (1997) provided evidence of the efficacy of both emotion-focused group therapy and problem-focused therapy in a study of clients with fertility problems. Although emotion-focused training was associated with greater improvement, including less depression and improved well-being one month after the training, problem-focused training was better associated with fertility at 18 months. Both types of psychotherapy were considered useful in the adjustment process, albeit via seemingly different pathways of adjustment.

Client process and outcome was compared in client-centred and process-experiential interventions for depression (Watson & Greenberg, 1996). Results of several observer-rated and self-report instruments indicated that process-experiential therapy was more effective on measures of experiencing, vocal quality, expressive stance, and problem resolution in two chair and empty chair interventions (Watson & Greenberg).

Not surprisingly, other studies found that PI therapists associated high degrees of emotional experiencing as critical to the change process, whereas cognitive-behaviour therapists associated lower levels of experiencing as therapeutically important (Wiser & Goldfried, 1993, 1998). However, observer-rated instruments identified comparable amounts of affective experiencing in change sessions of both CBT and PI therapies (Wiser & Goldfried, 1993).

In a randomized clinical trial, Watson, Gordon, Stermac, Kalogerakos, and

Steckley (2003) compared levels of depression, self-esteem, general symptoms distress, and dysfunctional attitudes in CBT and process-experiential psychotherapy. Results from self-report measures of the above variables indicated generally equivalent outcomes for both therapies, although interpersonal problems decreased significantly for clients in experiential therapy, which has more of an interpersonal component than CBT. Despite the high internal validity of this study, it excluded co-morbid disorders, personality disorders, and those with a high risk of suicide, thus greatly reducing the applicability of the study to general practice. These results are consistent with previous comparisons of the same therapies (Greenberg & Watson, 1998).

Much like his comprehensive approach to defining emotion, Plutchik (2000) encourages an approach to psychotherapy that is compatible with all forms of psychotherapy. His psychoevolutionary therapeutic approach of emotions in psychotherapy has the common goal of identifying emotions and recognizing their importance for each individual client. "Tactics" include identifying triggers, using metaphors, identifying the relationship between the function of the emotion and personality traits, redefining triggers, examining impulses, exploring ambivalence, exploring capacity to experience a range of emotions, balancing undesirable emotions and relieving stress.

Summary of Emotion Literature

The common underlying theme in these theories is that emotions are basic processes that are necessary to our functioning as individuals. They are essential informing agents for effective emotion regulation (Pavio & Greenberg, 2001). As such, the available research has succeeded in recognizing the importance of emotional processing across therapeutic modalities.

> These results are synthesized by Whelton (2004) who summarizes that when emotions are regulated sufficiently to be facilitated and processed, it is the combination of their arousal and processing and a more cognitive

> reflection on their meaning that produces the deepest therapeutic transformation... emotional events are processes, and that it is in facilitating these processes through structured sequences of a particular type at a particular time for a particular disorder that change is produced (p. 58-59).

The emotion literature across disciplines is increasingly demonstrating empirical support for the relationship between emotional experiencing and therapeutic change, regardless of therapeutic modality (Whelton). The recent empirical support for the relationship between emotional experience and positive outcome across all major psychotherapeutic orientations allows researchers to look beyond the comparison of methods.

A general consensus in acknowledging the role of emotions in therapeutic change has been established (Greenberg & Korman, 1993; Greenberg & Malcolm, 2002; Pos et al., 2003; Greenberg & Paivio, 1998; Whelton, 2004). Researchers have taken a big step forward by looking at clients' experience to augment therapists' perceptions of that experience. However, a true understanding of this experience may be gained by directing the client to talk about his or her emotional experiences. These subjective experiences, though important to access in psychotherapy, are not usually offered without direct inquiry.

Emotions in psychotherapy have been researched as an in-session variable (e.g., Paulson et al., 2002; Foa et al., 1995) at the expense of considering change and experience outside of counselling. In fact, the most obvious gap in the literature is the lack of attention to the emotional process, as experienced by the client in- and out- of session. Change is not confined to the psychotherapy session. Despite Stuart's (2002) identification of the emotional process in her study of emotional experiences in psychotherapy, no located study has directly attended to the emotional process of being suicidal. Further, it is notable that empirical attention on emotions consists of investigations of specific experiences (e.g., Paulson & Worth, 2002; Rennie, 1992) and restricted to specific samples (e.g., depression in MacKay et al., 2002; PTSD in Foa et al., 1995) or specific emotion events (e.g., anger in Mackay et al., 1998). In these instances, results may not always be generalizable other populations. Also, single session samples (e.g., Mackay et al., 2002) and some case studies (e.g., Lecours et al., 2000; Mackay et al., 1998) do not allow for an examination of the process.

Suicide Theory and Empirical Research

In 2001, 3688 Canadians took their lives by means of intentional self-harm (Statistics Canada, 2001). The suicide rate in Canada is two to three times higher for the Aboriginal population and five to six times higher for Aboriginal youth and has remained stable over the past 25 years (Statistics Canada, 2001). Statistics for attempted suicide are uncommon. With exception, a study conducted in Alberta, Canada found that Edmonton hospitals alone saw 2264 persons with 2780 attempts from February 1993 to February 1994 (Bland, Dyck, Newman, & Orn, 1998). These disturbing numbers coupled with the therapist's inevitable exposure to suicidal clients (Dexter-Mazza & Freeman, 2003) are important reasons for increasing our understanding of the suicidal experience.

As the following review indicates, the available research has focused on pragmatic aspects of suicide, such as risk factors and protective factors (Leenaars et al., 1998; Westefeld et al., 2000; Rogers, 2001) whilst suicide rates remain critical. Researchers are now focusing on the general psychotherapy experience of suicidal clients (e.g., Paulson & Worth, 2002) with results encouraging more direct inquiry on the emotional aspects of suicidality.

Conceptualization of Suicide

Suicidology is "the study of human suicide" (Shneidman, 1993, p. 637). Suicidality is described as those cognitive and behavioural characteristics that manifest as suicidal ideation or suicidal behaviour (van Heeringen, 2001). Suicide itself is described as "a conscious act of self-induced annihilation, best understood as a multidimensional malaise in a needful individual who defines an issue for which the suicide is perceived as the best solution" (Shneidman, 1985, p. 202).

All suicidal behaviour involves tissue damage, illness, or risk of death (Kreitman, 1977). Suicidal behaviour has three components: completed suicide, suicide attempts, and self-injurious behaviour, the former two of which usually involve the intention to kill oneself (O'Carroll et al., 1996). Self-injurious behaviour, including self-mutilation, is distinguished by the absence of fatal intention (Simeon & Favazza, 2001). Suicidal ideation involves thoughts about suicide. The term *parasuicide* is commonly used in the suicide literature, although there is no general consensus for its definition. Some people associate parasuicide with regulating emotions through actions (Kemperman, Russ, & Shearin, 1997) whereas others (e.g., Sakinofsky, 1998) have used the term to describe attempted suicide. Due to the confusion surrounding its definition, the term parasuicide will not be used in this study. For the purposes of this research, suicide for religious, cultural, or historical purposes (e.g., terrorist acts) will not be included. This study focuses on attempted suicide rather than completed suicide. Attempted suicide consists of suicidal behaviour with the intention to die.

The extent of the similarities and differences between those who complete suicide and those who attempt suicide is unknown, apart from the fact that more males than females complete suicide and use more lethal methods (Statistics Canada, 2001) and more females than males attempt suicide (Bland et al., 1998). There is overlap between attempted and completed suicides - a positive relationship has been identified between previous suicide attempts and completed suicide (Rogers, 2003). More research has been dedicated to completed suicides than attempted suicides although the processes involved in completed suicides are difficult to ascertain. Researchers have been creative with analyzing suicide notes (Leenaars, 1988) and reconstructing the suicidal experiences using interviews with family members, otherwise known as psychological autopsies (Shneidman, 1980a). Both types of suicide will be addressed in the remainder of this literature review. However, this study is about attempted suicide.

There is an incredible amount of research on suicide risk factors, mostly comprised of demographic factors. The following factors have been found to correlate with suicidality in comparison studies of suicidal and nonsuicidal groups in North America: depressive symptoms (Harrington, Fudge, Rutter, Pickles, & Hill, 1990), anxiety (Chance, Kaslow, & Baldwin, 1994), personality traits (Blatt, 1995), feelings of hopelessness (Cole, 1988), irrational beliefs (Woods, Silverman, Gentilini, Cunningham, & Grieger, 1991), fewer coping skills (Schotte & Clum, 1987), histories of physical and sexual abuse (e.g., Bendixen, Muus, & Schei, 1994), limited social support (D'Attilio, Campbell, Lubold, Jacobson, & Richard, 1992), alcohol use (Murphy & Wetzel, 1990), expression of verbal intent (Maris, Berman, Maltsberger, & Yufit, 1992), physical illness (Draper, 1996), adolescents, (Goldman & Beardslee, 1999), the elderly (Moscicki, 1999), men (Statistics Canada, 2001), highly competitive or fluctuating societies (Jilek-Aall, 1988), homosexual orientation (McBee & Rogers, 1997), and previous suicide attempts (Rogers, 2003). In Canada specifically, suicide rates are greater for males, the elderly, the Francophone population, and the First Nations population (Statistics Canada, 2001, 2002).

It should be noted that many of the above studies used specific populations such as psychiatric inpatients and adolescents that limit their generalizability. Westefeld et al. (2000) also cautions that it is misleading to view any of these correlates as independent factors in assessing risk for suicidal behaviour. Rather, suicide is a complex behaviour with a combination of etiological (National Institute of Mental Health [NIMH], 1999) and contextual factors.

Suicide and Psychotherapy Models

Traditional psychotherapeutic theories do not specifically address suicidology for the most part. However, more contemporary theorists have offered their interpretation of the intentions of traditional theories with respect to suicidology. The following is an overview of traditional and contemporary psychotherapeutic theories with respect to understanding and treating suicide.

Suicide and Humanistic and Experiential Psychotherapy. The Humanistic and Existential theorists view suicide as emanating from an individual's inability to discover meaning in life (e.g., Frankl, 1963). Humanistic approaches also emphasize the influence of the therapeutic relationship in overcoming suicidal ideation and behaviour (Rogers, 1957).

Yalom's (1980) model assumes life and death issues when one is considering his or her existence. According to Yalom, the awareness and anxiety one feels when considering his or her own death and meaninglessness is exacerbated by the experience of existential isolation which influences the other concerns of existence. The way in which one constructs his or her existence may impact on cognitive, affective, and behavioural levels, the latter of which may actively lead to fatality. In this respect, suicidal thoughts and behaviours are consequences that are logical to the person considering it (Shneidman, 1987).

In Carl Rogers' (1986) person-centred therapy, suicide is seen as an attempt to destroy the self. For suicidal persons there are aspects of their identity that are not acceptable. They may not know who they are and strive to destruct those aspects of the self that they see as unacceptable. Borrowing then from person-centred therapy, suicidal feeling and behaviours reflect incongruence between the ideal self and the real self. As such, the nondirective, empathic, congruence, and unconditional nature of the therapist (Rogers, 1957) is extremely important in working with suicidal clients.

Rogers and Soyka (2004) propose an existential-constructivist perspective aimed at humanizing suicide interventions. This existential-constructivist model (Rogers, 2001, 2003) was inspired by Rogers' synthesis of Yaloms' (1980) existential theory of psychotherapy and Neimeyer and Mahoney's (1995) critical constructivism. In this model, suicidal behaviour results from meaning-based cognitive structures of existential meaninglessness and isolation that influence how the world is experienced (Rogers, 2003). The phenomenological goal, then, is to individualize and "re-humanize therapeutic encounters with suicidal individuals by respecting them as the only true experts of their experience" (Rogers & Soyka). It focuses on the therapeutic relationship and allowing the client to tell his or her story.

Rogers and Soyka (2004), in their plea to improve traditional assessment and treatment practices, endorse the therapeutic assessment model (TA: Finn & Tonsager, 1997). The TA model emphasizes a collaborative, client-centred, therapeutic assessment experience for the client. Empirical evidence of the positive increases in treatment adherence using the TA model has been demonstrated (e.g., Ackerman, Hilsenroth, Baity, & Blagys, 2000) on nonsuicidal university outpatient students using clinical interviews, self-report measures, and the Rorschach.

Shneidman (2004) is one of the few suicidologists with a suicide model. His model acknowledges important multidisciplinary approaches to suicide but Shneidman himself focuses on the psychological experiences, which strongly complements a field largely informed by demographic research. Shneidman's psychological model is based on over 50 years of clinical experience and his research on suicide notes and psychological autopsies (e.g., Shneidman, 1977; Shneidman, 1971b). Shneidman emphasizes the need to mollify the pain fuelling suicidal behaviour. In doing so, he rejects the medical model interventions, which distances one from the person. Shneidman (1996) attributes the essential nature of suicide as being psychological despite the influence of biological, cultural, sociological, interpersonal, and philosophical forces. In this respect, he states that an understanding of suicide is achieved via the study of human emotions and the best route to achieve this understanding is by asking the person who is experiencing psychache or psychological pain.

Shneidman's (1987) psychological model consists of a cube with three planes. These planes are *press* (events interpreted as negative experiences), *psychological pain*, and *perturbation* or a state of being upset. An individual's risk for suicidal behaviour is assessed on each of the above-mentioned planes on a scale of one to five. The individual's level of motivation for ending the pain is also used in the assessment. In his approach, Shneidman attributes suicide to psychache whereas other theorists attribute it to nonpsychological variables, such as gender and age.

The ten commonalities of suicide, according to Shneidman (1987, p. 167-174) include the following:

1. The common purpose of suicide is to seek a solution.
2. The common goal of suicide is the cessation of consciousness.
3. The common stimulus in suicide is intolerable psychological pain.
4. The common stressor in suicide is frustrated psychological needs.
5. The common emotions in suicide are hopelessness and helplessness.
6. The common cognitive state in suicide is ambivalence.
7. The common perceptual state in suicide is constriction (of affect and intellect).
8. The common action in suicide is egression (persons intended departure from a region of distress).
9. The common interpersonal act in suicide is communication of intention.
10. The common consistency in suicide is with life-long coping patterns.

The link between emotions and suicide behaviour is direct, according to

Shneidman (1996). He attributes the act to *psychache*, or mental or psychological pain resulting from frustrated or thwarted essential needs. Psychache is, then, a combination of multiple maladaptive emotions (e.g., guilt, hopelessness, and grief) into a general state of emotional perturbation. Overall, Shneidman's conceptualization of suicide may perhaps be the most obvious and straightforward theoretical model. The main drawback of this model is that it is largely based on research on completed suicides for which suicide notes or psychological autopsies were available for analyses, which limits the generalizability of the model, especially in the case of attempted suicide and completed suicides without suicide notes. Nonetheless, Shneidman is an experienced clinician and his theory is also informed by over 50 years of working with suicidal persons.

The contention that psychological processes are different with suicidal individuals (e.g., emotions: Iancu et al., 1999) implies that psychotherapy, in its attention to emotional distress, needs to be different for suicidal individuals. For example, there may be a larger emphasis on increasing a felt sense of possibilities and sense of being emotionally supported (Shneidman, 1980b). Hendin (1981) suggests that the following ingredients are necessary for successful psychotherapy with suicidal individuals:

> Psychotherapy can be successful with suicidal patients if the therapist does not reduce therapy to management and control of the patient; understands the way in which the patient uses his potential death as apart of his adaptation; and avoids specific countertransference pitfalls (p. 469).

This traditional although prevalent thinking in suicidology emphasizes empathy and the therapeutic relationship.

Humanistic Research on Suicide. Researchers are venturing into a more discovery-oriented approach on the suicidal clients experiences. With respect to treating suicidal persons, Paulson and Worth (2002) conducted a qualitative study on previously suicidal clients counselling experiences, where they investigated helpful therapeutic conditions as identified by previously suicidal clients. Participants sorted statements made by other previously suicidal clients and identified the following factors as helpful in overcoming suicidal thoughts and actions: (a) validating relationships; (b) working with emotions; and (c) developing a new identity. The clusters *Overcoming Helplessness and Despair* and *Using Emotions for Change* are of particular interest for the present research. The affective component, and especially acknowledgement and validation of feelings of helplessness and despair, were crucial processes in overcoming suicidality. The predictive nature of emotional intensity in positive therapeutic outcome is consistent with other professional literature (Beutler et. al., 1999; Greenberg & Watson, 1998) as Paulson and Worth suggest. These results confirm the importance of emotions in overcoming suicidality and demonstrate the need for further exploration into suicidal clients' emotional experiences in counselling.

Another phenomenological study conducted by Hoover and Paulson (1999) also indicates support for further investigation into suicidal clients' emotional experience. Participants shared their experiences of *What was helpful to recovery*? in minimally structured interviews. Not unlike Bolger's (1999) conceptualization of Emotional Pain through the lens of the self, Hoover and Paulson described participants' stories of being suicidal by the metaphor of *A Journey Away from the Self.* Suicidal processes generated from these experiences involved suicidal person's disconnection from others and from the self, their feelings, self-worth, and their experiences of negotiating their lives. The healing process was described as a reconnection with self and others and involved constructing new perspectives in *The Return to the Self.* Overall, these studies presented the suicide process from the perspective of the client, leading the way to essential research and practice considerations involving more in-depth attention to the client's experience and the role of emotions in that healing process. Like Bolger's study on emotional pain, this study highlights the changes within the self, also mirroring Rogers' (1957) conceptualization of the real self and ideal self.

The meaning of suicide attempts was explored by Everall (2000) in a qualitative study of the experiences of young adults who attempted suicide in their early 20s. Interviews were analyzed using an interpretive inquiry method. Results identified six themes: family experiences, adolescent interactions, emotional experiences, self-destructive behaviours, depression, and perception of control. With respect to emotional experiences, negative emotional experiences throughout the life span were identified as forming a gestalt of suicidal feelings. This emotional pain fuelled other emotions, impacting on self-worth, insecurity, and anger turned inward. Feeling rejected and fear of being rejected was common among participants. Alienation from others was seen as a pattern beginning in childhood that developed into a self-protective function to preserve oneself from hurtful interactions. This study contributed an understanding of the progression of suicidal behaviour from a developmental perspective.

Paulson, Everall, and Murray (in press) used basic interpretive qualitative methods to explore previously suicidal adolescents hindering psychotherapy processes. They found hindering experiences to be centred on two themes. First, impediments to the therapeutic relationship included participants' experiences of inadequate collaboration, insufficient engagement, and violation of confidentiality. Secondly, hindering therapist interventions included participants' descriptions of having their suicidal experiences minimized, restricted therapeutic focus, and premature problem-solving. This study is important in identifying therapists' awkwardness and anxiety with suicidality, thereby identifying the need for therapists to explore their anxieties.

Orbach, Mikulincer, Sirota, and Gilboa-Schechtman (2003) conceptualized mental pain in the context of an awareness of negative changes and negative feelings across a wide range of subjective experiences. They created the Orbach and Mikulincer Mental Pain (OMMP) Scale, which is based on the following nine factors generated from content analysis of self-reports: lack of control, irreversibility of pain, emotional flooding, narcissist wounds, estrangement, confusion, emotional flooding, need for support, and emptiness.

Orbach, Mikulincer, Gilboa-Schechtman, and Sirota (2003) tested Frankl's (1963) proposition that the loss of life meaning is related to intense psychological pain using the OMMP Scale. They compared self-rating scales of suicidal and nonsuicidal persons to investigate mental pain and its relationship to life meaning in both groups. Results differentiated suicidal persons by the following OMMP factors: irreversibility, loss of control, and especially emptiness. This finding provided support for the hypothesis that suicidal feelings are significantly related to Frankl's (1963) proposed relationship between loss of life meaning and mental pain.

Edwards and Holden (2003) investigated life meaning and coping strategies as predictors of suicidal ideation using self-rating scales of coping, sense of coherence (meaningfulness), purpose in life, hopelessness, and suicidal ideation. They found that sense of coherence and emotion-oriented coping (as opposed to more adaptive problem-solving forms of coping) more strongly contributed to suicidal attempts for women than for men. They found partial support for the hypothesis that life meaning operates as a buffer between a person's coping style and suicidal ideation. Interestingly, this study did not provide support for the use of hopelessness as a predictor of suicide for men or women, thereby contradicting Shneidman's (1987) emphasis on hopelessness as a commonality of suicide. The fact that Edwards and Holden used Beck's hopelessness scale, which was used on psychiatric patients, may account for this discrepancy.

Suicide and Cognitive Behavioural Psychotherapy. Much research in the cognitive behavioural tradition does not have applicability to suicidality because the suicide population is not included in those studies. For example, a multidimensional meta-analysis conducted by Westen and Morrison (2001) on cognitive, behavioural, and medication treatments for depression, panic, and generalized anxiety disorder (GAD) looked at studies published in the decade of the 1990s and excluded dual diagnoses, suicide, and alcoholism from the study. Results suggested long-term improvement for the treatment of panic, short-term effects of treatment for depression and GAD, and lack of significant long-term improvement for depression and GAD. Westen and Morrison raise concern about the generalizability of previous studies using strict experimental control along with the exclusion criteria used in the meta-analysis, which severely limits their applicability to the reality of psychotherapy, such as in the case of working with suicidal clients. As such, the external validity of empirically validated treatments is becoming a recognized quandary.

Behavioural treatment of suicidal behaviours has two strategies according to Linehan (2000). First, suicidal behaviours are a symptom of another problem, which when alleviated, results in a decrease in suicidal behaviours. Secondly, reductions in suicidal behaviours must be addressed directly. The psychotherapy agenda consists of helping the client to make the connection between underlying or controlling factors and suicidal behaviours and ideation.

The most widely known behavioural treatment for suicidal behaviour is dialectical behaviour therapy (DBT), a psychosocial treatment based in a motivational-skills deficit model that acknowledges that persons with borderline personality disorder lack interpersonal, self-regulation, and distress tolerance skills (Linehan, 1993). This model combines structured individual and group skills training targeting the reduction of suicidal behaviours with the above skills. The empirical effectiveness of the model has been demonstrated (e.g., Linehan, Heard, & Armstrong, 1993) by the reduction of suicidal behaviour.

Other behavioural treatments for suicidal behaviours in persons with borderline personality disorder include a behavioural activation treatment for depression (BATD: Lejuez, Hopko, & Hopko, 2002). The BATD is based on the idea that behaviours are choices maintained by consequences and therefore open to reinforcement for alternative behaviours. Treatment protocol includes examining the function of the behaviour and establishing rapport in the initial session. Patients teach family and friends to focus on their efforts to engage in healthy alternatives in order to reduce reinforcements of the suicidal behaviours. Problem solving skills are taught and behavioural contracts, tracking forms for daily activities, and other self-monitoring principles are used. An activity hierarchy of adaptive behaviour is constructed and accomplished. This treatment approach is brief compared to Linehan's (1993) DBT and theoretically consistent, although it does not include mindfulness, distress tolerance skills, or social skills training. Both DBT and BATD were developed for Borderline Personality Disorder (BPD) and their effectiveness with suicidal persons who do not have BPD has not been clearly established.

Cognitive behavioural approaches are more common than behaviour approaches alone in the treatment of suicidal behaviour. Cognitive therapy applied to suicidality attributes suicidality to maladaptive belief systems (e.g., helplessness, poor distress tolerance) in the context of hopelessness (Rudd, Joiner, & Rajab, 2001). Rudd et al. (2001) used Beck's cognitive behaviour theory as a framework for a cognitive behaviour model of suicidality. In this framework the *suicidal mode* consists of thoughts about killing oneself (cognitive system), feelings of dysphoria - negative mixed emotions (affective system), preparatory behaviours (behavioural system), and arousal (physiological system) - all systems of which are running concurrently. Rudd et al. present a treatment model based on this cognitive behavioural framework. The general goal of the model is to deactivate the suicidal mode by simultaneously addressing the symptoms, deficient skills, schemas, and maladaptive personality traits, from a cognitive, affective, and behavioural perspective. Of course, the process begins with resolving any immediate crisis. They emphasize the potential increase in positive outcome with long-term treatment.

Rudd (2004) identified parallels between his suicide mode model and Shneidman's (1993) psychological pain model. He acknowledged the different, yet complementary, emphasis of other theoretical approaches in his argument for theoretical integration. Despite the fact that Rudd's model is grounded in a pre-existing theoretical framework, it is not grounded in suicidal clients' experiences. This theory is similar with Shneidman's psychological pain model, although the later is grounded in suicidal clients' experiences from his clinical experiences.

Suicide and Psychodynamic Psychotherapy. Psychodynamic theory contributes an interpersonal and intrapersonal understanding of suicidal needs. There are several psychodynamic theorists with writings on suicidology, among them, Freud, Kohut, Menninger, Hendin, and Huprich. Freud considered suicide as an internalised act of aggression towards another (Freud, 1917/1974), in order to relieve anxiety resulting from failure of the superego (Freud, 1923), usually in the context of loss or rejection of an attachment figure. In this perspective, suicidal tendencies represent a struggle between the life and death instinct, with fatality being dependent on a death wish turned against oneself. Finally, Freudian theory attributes suicidal ideation and behaviour as a failure to cope as represented by regression or fixation on a psychosexual stage (e.g., oral). From this perspective, the therapist helps the client to re-experience and restructure unconscious material via free association, dream analysis, and building ego strength (Stillion & McDowell, 1996). Kohut (1977) attributes suicide to a defence mechanism against the breakdown of the person's sense of self in the context of intolerable disintegration anxiety resulting from unmet narcissistic needs.

Menninger (1969) also attributes the wish to kill to broken attachments and displacing resentment and hostilities onto oneself, which indirectly hurts the attachment figure in a process of introjection. Menninger attributes suicide to the death instinct. In this respect, a person has limited inner personal strengths and defences against one's own self-destructive urges. He emphasized three basic motives in suicidal behaviour: the wish to kill, the wish to be killed, and the wish to die at conscious and unconscious levels. He suggests that suicide may be a substitute for something far worse.

Hendin (1991) summarized affective, cognitive, and early experiences in the literature on the psychodynamics of suicide. With respect to the affective component, suicidal patients generally have much rage, hopelessness, despair, desperation, and guilt. Reunion with a lost object is the main cognitive work for suicidal persons. Early experiences, especially in the case of a deceased parent are associated, like Kohut (1977) with narcissistic injury in a suicidal person. With respect to treatment, Hendin suggests free association and dream analysis in uncovering conscious and unconscious motivation for suicidal behaviour and helping the person to understand their suicidal feelings as a means to reconnect with a lost object.

Attachment theory also contributes to our understanding of suicide. Bowlby (1988) described attachment as a biologically based motivational control system that monitors caretakers and promotes proximity to those caretakers for protection and survival. An overactive control system, then, is thought to develop from experiences of loss or abuse. From the perspective of attachment theory, suicidality was found to be associated with unresolved and disorganized attachment responses in interviews, such as the Adult Attachment Interview (Adam, Sheldon-Keller, and West, 1996), at least for adolescents.

Huprich (2004) conceptualizes suicidal ideation as the product of conscious and unconscious mental activity. He describes a suicide attempt as the "result of intrapsychic factors that work against the physical being to bring about complete destruction" (p. 24). As such, suicidal behaviour in psychodynamic theory is a conglomeration of conscious and unconscious affects, impulses, and wishes, both pleasurable and painful.

Psychodynamic Research on Suicide. Empirical attention to psychodynamic thought on suicidality has focused on assessing levels of depression, anger, loss history, defences, and object representations in suicidal verses nonsuicidal populations. For example, Kaslow et al. (1998) compared self-reports and projective measures of the above variables in a psychiatric inpatient sample. They found no differences between attempters and nonattempters on measures of self-directed aggression and defences. However, more losses were calculated for the suicide attempters. Object relations for attempters were also characterized by more emotional negativity, less emotional investment, less complexity, and poor levels of separation-individuation. These findings lend support for the differentiation of attempters by internalized object relations, thereby lending support to Hendin's (1991) theory.

These results were confirmed in a further study by Twomey, Kaslow, and Croft (2000), with self-report and clinician rated measures of object relations with African American females. Twomey et al. also demonstrated positive correlations between attempters and higher levels of sexual, physical, and emotional abuse, and emotional and physical neglect. These results suggest interpersonal sensitivity and anxiety, including negative interpretations of therapeutic interventions, suggesting that the therapeutic relationship is very important in psychotherapy (Huprich, 2004).

Of particular relevance to emotions in suicidality, Jessee, Chance, D'Orio, and Edelson (1996) found a greater intensity of emotions, particularly, anxiety, confusion, guilt, hopeless, and sadness on observer ratings of interviews with psychiatric inpatient attempters when compared with psychiatric patients who had never made an attempt. These results corroborate with Iancu's et al. (1999) finding that the suicidal person experiences greater intensity of emotions, further implying that suicidal individuals experience emotions differently than nonsuicidal individuals.

All of the above studies on suicide discussed thus far have focused on attempters. The empirical attention to completed suicides has remained at the demographic level, with the exception of few studies using suicide notes as data. For instance, Leenaars and Balance (1984) found that the following items differentiated genuine from simulated suicide notes: loss or rejection of a significant person, preoccupation with the loss or rejection, ambivalence, reported identification with a rejecting or lost person, communicating feelings/ideas of vengefulness and aggression toward oneself, turning murderous impulses onto oneself, punishment, and death wish which was formerly directed at another person. These results are limited to the availability of suicide notes and to persons who wrote notes as opposed to those who do not.

The main implication for treatment prescribed by the above theory and research on psychodynamic perspectives on suicide concerns the therapeutic relationship, which is consistent with the humanistic tradition. In treating suicidal persons, therapists should strongly consider their anxieties and expectations of responsibility in working with such a population, especially in matters of transference and countertransference (Huprich, 2004). Further, Huprich advises that clinicians be familiar with suicide management and self-destructive motivating psychic conflicts. Overall, psychodynamic approaches to treating suicidal individuals acknowledge interpersonal and developmental factors in understanding the person.

Multidisciplinary Theories of Suicidology. Most other existing models view suicide from a multidisciplinary perspective (Pedhazur & Schmelkin, 1991). Leenaars' (1988) multidimensional model of suicide is based on clinical experience and research on suicide notes. His model bears many similarities with Shneidman's (1987) psychological model of suicide. Suicide is described as a multidimensional malaise constituted "by a painful situation, a disturbing relation, an overpowering emotional state, a constricted cognitive state, and the persons own ego" (Leenaars, 1988, p. 207). Leenaars' model has intrapsychic and interpersonal dimensions. With respect to the former, he adopts Shneidman's concept of psychache to describe the unbearable psychological pain that, according to Menninger (1969) feels like it will never be relieved unless action is taken to relieve the pain. The cognitive state of suicide is one of rigidity and constriction. Ambivalence is the surface of other unconscious processes.

The interpersonal dimension of Leenaars' (1996) multidimensional model of suicide consists of difficulties establishing or maintaining relationships, leading to unsatisfied attachment needs and feelings of rejection or abandonment. This unbearable narcissistic injury leads to self-directed aggression. Intense identification with this lost or rejecting person leads to the need to leave or to be dead. This adjustment function is parallel with Shneidman's (1987) idea that the purpose of suicide is to seek a solution.

Instead of being a survival function, suicide has an adjustment function perceived by the suicidal person as the best solution. Suicide is seen as the only way to reduce the tension of pain from blocked needs. This inability to adjust implicates impaired or inefficient coping skills, such as ego strength. Both Shneidman (1985) and Leenaars (1996) agree that suicide is closely related to lifelong adjustment patterns or coping deficiencies.

Like Shneidman, this theory is largely based on research on suicide notes (e.g., Leenaars, 1989) and captures the complexity of the parameters of completed suicide. However, its relevance and applicability to attempted suicide may only be assumed for now. With exception, Leenaars, Lester, and Yang (1992) compared suicide notes from completed and attempted suicides. Results showed no differences in content, although notes were compared only on Menninger's list of motives for suicide.

Jobes (2000) argued that "the presence and/or absence of certain key relationships can paradoxically be suicide causing and suicide preventive" (p. 8). For instance, individuals who seek the counselling relationship have not necessarily made a firm decision to die, therefore identifying the therapeutic relationship as one with potential protective power against suicide. Jobes questions the use of hospitalization in the treatment of suicidal clients, arguing that it gives the client rejection messages - a negative relationship experience. He urges clinicians to acknowledge that clients see suicide as a logical option, opening the door for cognitive restructuring in a collaborative fashion. In this collaboration, the clients own phenomenological motives and experiences are considered and taken seriously. Jobes acknowledges the emotions identified in other models (e. g., psychache, pain, hopelessness, agitation, self-hate, press) as being the "essential underpinnings of suicidal states" (Jobes, p. 14).

Jobes (2000; Jobes & Drozd, 2004) presents the *Collaborative Assessment and Management of Suicidality* (CAMS) as an integrative model of treating suicide. CAMS is a clinical assessment tool designed to identify suicidal clients and engage them in a co-authored problem-solving treatment plan. The CAMS inclusion of the collaborative assessment process and delivery of treatment in the context of an emphasis on the therapeutic alliance, as well as the empirical validation of the CAMS system, (Jobes, Wong, Drozd, Kiernan, 2002) set it apart from earlier therapies to predict and treat suicide. It is based on one of the most theoretically integrative approaches to suicidality, with emphasis on Shneidman's (1993) concepts of psychache, press, and perturbation and Linehan's (1993) DBT, as well as behavioural, cognitive, psychodynamic, humanistic, and interpersonal approaches.

The CAMS model utilizes brief risk assessment instruments at regular intervals that are not too demanding on the patient. If ideation is revealed, client and therapist sit side by side to complete the Suicide Status Form, by handing it back and forth. This approach provides ample opportunity for discussion and alliance based treatment planning. This model provides a comprehensive approach to treating suicide ideation with the added benefits of evidence-based research. However, the many forms required in the assessment process were likely time-consuming and difficult, especially for depressed clients who may not feel able to participate.

In the Overlap Model, Blumenthal and Kupfer (1986) present high risk suicide as occurring in the interaction of the following domains: psychosocial; biological; psychiatric; personality; and genetic. Blumenthal and Kupfer present their model in a Venn diagram with high risk represented in overlapping circles of the vulnerabilities intended in each domain. These vulnerabilities consist of levels of social support, development, various disorders, various personality traits, and family history.

In the Three Element Model, Jacobs, Brewer, and Klein-Benham (1999) emphasize the influence of predisposing factors, potentiating factors, and suicidal threshold in one's decision towards suicidal behaviour. These factors are consistent with Blumenthal and Kupfer's focus on psychiatric disorders, family history, and social milieu, with the inclusion of life stressors. All of these factors are thought to clash together to push an individual towards or away from suicidal behaviour.

Stillion, McDowell, and May (1989) propose another multidimensional model that includes the above dimensions from a developmental perspective. This Suicide Trajectory Model emphasizes the influence of triggering events in suicidal thoughts. It combines biological (e.g., genetic predisposition as in depression), psychological (e.g., hopelessness), and cognitive risk factors (e.g., cognitive rigidity) with a triggering event that may result in suicidal behaviour.

In contrast to theories based in knowledge of risk factors, van Heeringen (2001) offers a process-based model of suicide. His process model reflects a stress-induced, trait-life predisposition for suicidal behaviour, whereby trait-like propensities influence one's interaction with the environment in a process that develops over time. For example, past events may sensitize a person to viewing themselves as failures or feeling trapped. van Heeringen acknowledges three biological systems in the neurobiological part of his theory: overactivity of the hypothalamic-pituitary-adrenal axis, serotonergic dysfunction, and hyperfunction of the noradrenergic system.

Almost every treatment model, including those already discussed, fits loosely into two approaches. The Crisis Intervention Model (Pulakos, 1993) emphasizes the limited time frame of the suicidal state. As suicide is viewed as preventable the main therapeutic goal is to keep the individual alive until the crisis passes. Proponents of this model encourage therapists to take an active and authoritarian role more indicative of a dependent relationship than a therapeutic relationship during suicidal modes.

The other approach, the Continuing Therapy Model (Pulakos, 1993), focuses on suicidal ideation or parasuicide as opposed to the more crisis oriented focus of the Crisis Intervention Model. This model attributes suicide ideation and action to chronic behaviour patterns more than acute crisis. It assumes that suicide cannot be prevented thus placing more responsibility on the suicidal individual. Interventions involve fostering problem-solving behaviour while maintaining regular psychotherapy structures. Generally, this model emphasizes a process approach, such as that offered by van Herringen (2001).

Suicide and Emotion

Regardless of theoretical orientation, "clinical work is generally concerned with emotional disorders, emotional illness, and emotions that have gone awry" (Plutchik, 2000). The contention that emotions represent symptoms (Plutchik) adds further credibility to the role of emotion in psychotherapy and the reasons for seeking psychotherapy. The key to understanding suicide is through emotions (Shneidman, 1996) although few researchers have directly examined the relationship between emotions and overcoming suicide. Together, the above research studies show that emotions are important factors in overcoming suicidal ideation. For example, investigations of psychotherapy experiences have identified working with emotions as helpful in overcoming suicidal ideation and behaviour (Paulson & Worth, 2002). Further, investigations of coping styles associated emotion-oriented coping to suicide attempts for women (Edwards & Holden, 2003).

Iancu et al. (1999) examined the relationship between negative affect and suicide in a comparison study of 20 depressed suicidal patients, 20 depressed nonsuicidal patients, and a control group of 20 on self-report measures of alexithymia, emotional range, and affect intensity. They found that depressed suicidal and depressed nonsuicidal patients demonstrated similarly narrow ranges of emotion with suicidal patients experiencing greater intensity of emotions. Hopelessness and depression severity emerged as greater predictors of suicidal risk. Iancu et al. suggest that practitioners focus on reducing the intensity and increasing the range of emotions in order to reduce the severity of the depression and feelings of hopelessness that are thought to lead to suicidal behaviour. It is difficult to present conclusive findings on this study with the small sample size and the exclusion of a non-depressed suicidal group.

Seidlitz, Conwell, Duberstein, Cox, and Denning (2001) investigated emotion traits in older depressed suicide attempters and non-attempters. Emotion traits included in the analysis were Warmth, Positive Emotions, Anxiety, Anger/Hostility, Sadness, Guilt, and Self-consciousness. Through univariate and multivariate analysis of self-report measures, they found that emotion traits are related to suicidal behaviour according to the specific type of emotion and suicide variables examined. Specifically, attempters were lower in Warmth and Positive Emotions in univariate tests and lower levels of anxiety were associated with suicide attempts in multivariate tests. In addition, they found that Anger/Hostility and Guilt were associated with numerous suicide attempts. However, the lethality of method was related to less guilt. As such, those having a more lethal risk of death from suicide may appear to be in better emotional health than those with lower risk are. Seidlitz et al. acknowledged the influence of moods on their analysis. These results influence risk assessment focuses, directing the clinician's attention to a relative lack of Warmth and Positive Emotions, than by negative emotions. Although this study provides crucial information to the field of counselling, the suicidal person's subjective experience in this respect continues to remain unexplored.

Others have speculated the importance of emotions in understanding suicide. For example, Lester (1997) suggested that shame play a role in suicide. He indicated the potential for explaining the connection between the demographic factors associated with suicide and shame. He suggested that suicidal thoughts and behaviours result from the motivating influence of this powerful emotion in instances when individuals are experiencing unemployment, psychopathology, jail time, and developmental stages such as adolescence.

Cole (1988) also looked at specific emotions in his correlational analysis of individuals seeking treatment and individuals not seeking treatment. He attributes feelings of hopelessness to parasuicide for individuals seeking treatment. However, he did not solicit clients understanding of those feelings.

Subjective Experience of Being Suicidal. Overall, empirical attention to suicide largely depicts a disorganized array of symptomology and characteristics of suicidal individuals (see Leenaars et al., 1998 for Canadian review and Westefeld et al., 2000 for American review). Prevention is needed to reduce suicide rates and knowledge of the subjective experience of being suicidal is needed to inform prevention strategies. The subjective experience of being suicidal is becoming recognized as an essential part of understanding suicidal experiences. As researchers delve into more discovery-oriented methods of looking at the suicidal experience (e.g., Everall, 2000; Hoover & Paulson, 1999; Paulson & Everall, 2003; Paulson & Worth, 2002), emotions are emerging as an important experience in that process.

In fact, experts at an international workshop on suicide have identified the subjective experience of patients attempting suicide as an important yet unexplored aspect of being suicidal (Michel et al., 2002). These experts examined videotaped interviews of suicide attempters and agreed that the subjective experience of the suicidal person is largely ignored. Although these results are based on assessment interviews, the applicability of similar approaches to the research field is obvious: A better awareness of the subjective experience of being suicidal be can help to strengthen the therapeutic alliance, which is a known contributor to positive outcome in treatment (Martin, Garske, & Davis, 2000). Michel et al. encourage practitioners to use collaborative and narrative approaches that both increase therapist empathy and strengthen the alliance.

The importance of soliciting clients' perspectives (Heppner, Rosenberg, & Hedgespeth, 1992; Paulson et al., 1999; Sells, Smith, & Moon, 1996) stems from the knowledge that clients accounts often differ from those of therapists (Elliott & James, 1989; Orlinksy & Howard, 1986) and also from evidence that clients frequently defer to the therapist (Rennie, 1994). As the experts on their experiences, articulate clients can communicate important information with respect to their emotional experiences. It seems that the ineffectiveness of existing treatment models has given researchers and therapists permission to go back to square one and ask clients, as was the case in recent studies (e.g., Paulson & Worth, 2002). Many components of an emotional response have been identified, such as facial expressions, physiological changes, cognitions, behaviours and the subjective experience of emotions. It is the subjective experience so suicidal individuals that is explored in this research.

Summary of Suicide Literature

The theoretical state of the field of suicidology is growing rapidly. Many practitioners are combining information gained over the years into multidimensional models of suicide (e.g., Leenaars, 1998) in order to remedy the narrow focus of many existing theories (Rudd et al., 2001). Although there are numerous perspectives from which to understand suicide assessment and treatment, all seem to agree that suicidal behaviour is a symptom, a secondary aspect of a more primary problem (Rudd, 2004). In addition to the traditional medical model, a more process-oriented approach to understanding suicidal feelings is developing (Jobes, 2000; Rogers & Soyka, 2004; Shneidman, 1987).

Some suicide theories are based on completed suicides (e.g., Shneidman, 1980; Leenaars, 1988) whereas others are based on attempted suicides of specific populations, such as borderline personality disorder (e.g., Linehan, 1993). The truth is that suicide is complex. Suicide is not the same for everyone. Treatment is different for suicidal persons.

Conclusion

Therapists find themselves in a sensitive position with suicidal clients but they are still lacking a deep understanding of the role of emotions in experiencing and overcoming the state of being suicidal. A review of the current literature on emotions in the context of suicidality emphasizes some important information for theorists and clinicians working with suicidal persons:

- A myriad of demographics have been empirically identified as suicide risk factors that have been transformed into numerous assessment devices and management strategies that have failed to significantly alter the suicide rate (Rogers & Soyka, 2004). There is also an abundance of research on completed suicides (Shneidman, 1977, 1980; Leenaars, 1988). The literature is less versed in attempted suicide and specifically about the process of suicide and the experience of suicidal individuals. Specifically, attention to the demographic correlates of suicide escapes an important variable, psychache or psychological pain (Shneidman, 1993). A closer look at this process, especially from a theory-building perspective (Shneidman) may allow counsellors to better assist clients struggling with suicidal thoughts and behaviours.

- The subjective experience of being suicidal is considered a significant aspect of therapist empathy and the therapeutic alliance (Michel et al., 2002; Everall, 2000; Hoover & Paulson, 1999; Paulson & Everall, 2003; Paulson & Worth, 2002).
- There is growing evidence that the emotional experiences of clients have an impact on overcoming issues for which counselling is sought (Bolger, 1999; Clark, 1996; Greenberg & Safran, 1990; Paulson et al. 1999; Stuart, 2002). Emotions have been implicated in recovery from direct and indirect inquiry (Paulson & Worth) and there is evidence that suicidal persons experience emotions at a greater level of intensity when compared with nonsuicidal persons (Iancu et al., 1999). However, suicide research has not yet directly addressed the emotional process of being suicidal.
- Recently, there has been a phenomenological trend in understanding the suicidal experience (Everall, 2000; Rogers & Soyka, 2004; Paulson et al, in press; Paulson & Everall, 2003). However, this trend has not yet developed into focused attention on the emotional process of being suicidal.

Recently, researchers have begun to delve into the experiences of previously suicidal clients (e.g., Everall, 2000; Hoover & Paulson, 1999; Paulson & Worth, 2002; Paulson & Everall, 2001), thereby giving them a voice. This has brought the mental health field one step closer to understanding the complexity of being suicidal. However, no located study directly addresses the emotional experiences of suicidal persons, despite clients' insistence that emotional experiences are crucial to recovery (Paulson & Worth, 2002). More could be done on the subjective experience of emotion but also nothing has been done on the emotional process of feeling suicidal. Consequently, the focus of this study is to explore the emotional process of being suicidal, from the perspective of previously suicidal clients.

The preceding literature review provides the rationale for exploring the emotional process of being suicidal, from the suicidal person's perspective. The next chapter presents the rationale for the use of grounded theory methods of analysis. Processes involved in data collection and analysis are explained in detail.

Chapter Three

Method

This chapter describes grounded theory methods. They were chosen to provide a base from which to generate a better understanding of the emotional process of being suicidal and to generate subsequent validation studies that may inform theory development and more successful interventions with suicidal persons. This chapter also describes data collection and analysis procedures, credibility issues in grounded theory methods, and ethical considerations of the study.

Research Design

Qualitative research in psychology has experienced a dramatic rise over the last decade (Rennie, Watson, & Monteiro, 2002). Qualitative methods were chosen for the current study based on the goals of the research, the nature of the inquiry, and the shortage of research in the substantive area. The existing literature neglects essential information from clients about their experience during periods of high lethality, despite the vast array of research on the correlates of suicide (Leenaars et al., 1998; Rogers, 2001; Westefeld et al., 2000) and on emotional experiences in psychotherapy (Stuart, 2002; Whelton, 2004). Qualitative methods are appropriate for these new and unstructured areas because they attempt to explain and describe rather than confirm. As such, the current research employs qualitative inquiry, based on a naturalistic paradigm (Lincoln & Guba, 1985), which aims to understand a process using the participant's interpretation.

The purpose of my investigation of suicidal clients' emotional experiences follows the same purposes that suit qualitative research in this post-positivist era. In particular, the purpose of this study was to understand and explain the meaning, context, and process (Maxwell, 1996) of suicidal clients' emotional processes. The nature of this study prescribes qualitative inquiry, based on naturalistic paradigm (Lincoln & Guba, 1985) which has the following characteristics:

1. The goal of naturalistic paradigm is to understand the process.
2. Naturalistic paradigms enlist the participants' interpretation.
3. Naturalistic paradigms are inquiry based.
4. Naturalistic paradigms acknowledge the existence of multiple realities.
5. Naturalistic paradigms allow a broader category of methods to be employed.

Grounded theory is increasingly associated with qualitative research despite the fact that it is a general method (Glaser, 1999). It is considered by some (e.g., Denzin & Lincoln, 1994) to be the fifth movement of qualitative research. This grounded theory approach has roots in sociology. It "is a general methodology of analysis linked with data collection that uses a systematically applied set of methods to generate an inductive theory about a substantive area" (Glaser, 1992, p. 16). Further, it is a discovery-oriented approach that identifies and relates constructs and categories to explain processes of abstract problems. As such, grounded theory methods offer a viable option for a phenomenon that is new to the researcher and the theorist, such as the field of suicidology. Grounded theory tends to be one of the more validated and tested qualitative methods and it is becoming a method of choice by counselling researchers.

The epistemological foundations of the grounded theory method have been a matter of debate since the method was originated by Glaser and Strauss (1967), who both endorsed the constant comparative approach to analysis. Although both come from a sociological background, they eventually disagreed on some basic aspects of the approach. Strauss and Corbin (1990) argued for an instrumental rationale for the method whereas Glaser argued that it represents an inductive inquiry. Rennie (1998, 2000) argues for the grounded theory method from the point of view of methodological hermeneutics where the testing of hypotheses from a hermeneutics perspective is checked by the phenomenological procedure of bracketing. This process of recognizing one's own biases in the generation of communicating data in a meaningful manner reflects multiple interpretations of experiences. My use of the method endorses Glaser's traditional discovery-oriented and inductive nature of inquiry with sensitivity to the multiple interpretive nature of knowing.

Grounded theory methods of analysis were chosen as a suitable method for this study for several reasons. The field of suicidology is relatively new with few comprehensive theoretical guidelines based in clients' experience. Suicidology is an area flooded with existing studies but lacks information grounded in the client's experience. The grounded theory method allows a more abstract lens to view phenomena that are impersonalized in demographic research. Grounded theory methods allow enough abstraction to include the emotional process of being suicidal and to allow for variability of experiences. It is essential to indulge in a better understanding of suicidal clients' emotional experiences before more specific research questions can be addressed. Otherwise researchers would be adding to the fragmented nature of both fields of emotion and suicide.

More specifically, this particular research aims to uncover a *process*, which is also a primary purpose of grounded theory. These methods allow a discovery-oriented, explanatory analysis of a process via a systematic and inductive approach, which perfectly matches the state of suicidology research. Grounded theory methods allow the researcher to achieve an explanation of the process (Osborne, 1994) that this study aims to uncover. Specifically, the constant comparison analysis of grounded theory methods allows for an ongoing and dynamic analysis of the process of emotional experiences of suicidal clients.

From a more practical point of view, the technique of theoretical sampling contributes the time advantage and of guided sampling at all levels of analysis (e.g., participant selection, transcription, and use of questioning). This particular advantage also allows the researcher to use judgment in his or her ability to recognize emerging theory and ideas (Glaser, 1992). In this respect, it decreases the chance of accumulating unanalyzed data, a common occurrence in research projects (Glaser).

All basic features of the grounded theory method were used in this study. They include theoretical sampling, constant comparative data analysis, theoretical sensitivity, memo writing, identification of a core category, and theoretical saturation (Glaser & Strauss, 1967). On a philosophical and practical level, grounded theory research offers many options to researchers (Annells, 1997). Some researchers use the methods to generate theory and others use the methods to generate a better understanding of a process or phenomenon, sometimes labelled *grounded insight*. In this study, my intentions were to explain a substantive or empirical area rather than generate formal psychological theory. In other words, this research employs the classic mode of grounded research (Glaser & Strauss) within an inquiry paradigm. Although I do not reject Strauss and Corbin's (1990) reformulation of the traditional mode, their adoption of a constructivist paradigm of inquiry does not suit my research intentions of gaining an understanding versus constructing a theory. As well, my research fits with Glaser's emphasis on the traditional mode of discovery.

Data Collection

Selection of Informants. Potential participants were selected from their response to a newspaper advertisement (see Appendix B). The following inclusion criteria were used for selecting participants:

1. Past psychotherapy during or after suicidal ideation/behaviour;
2. Willingness to discuss their experience with the researcher;
3. Made a suicide attempt (s) towards fatality not less than one year

previously; and

4. Eighteen years of age or older.

I defined a suicide attempt to participants as suicidal behaviour with the intention to end one's life. Recruitment operated under the principles of theoretical sampling and continued until the point of saturation was reached, whereby new cases were not adding to the core category. I ended data collection after eight interviews, with four of them also submitting diary entries spanning the time that they were suicidal. I collected data between February 2002 and May 2002, with follow up contact continuing until June 2004. A gift certificate was offered to each participant upon completion of the interview, as a token of appreciation.

Participants included six Caucasian females and two Caucasian males aged 20-69 years, with a mean age of 44.5. The age of suicidal behaviour ranged from 13 years of age until middle adulthood, with six of the participants reporting suicidal behaviour in adolescence and all participants reporting suicidal behaviour as adults. Types of suicide attempts included overdose of prescription and nonprescription medications, slashing wrists, ingestion of poisonous substance, hanging, and stabbing with a sharp object. The length of time that participants were suicidal is difficult to describe given the different levels of lethality in the suicidal process and the variable speeds of suicidal cycles. As a group, the length of time that participants considered themselves to be suicidal ranged from one year to 40 years, keeping in mind that they were not necessarily at high lethality levels for the entire time. All participants reported at least one serious suicidal attempt that required hospitalization. Six of the participants reported multiples suicide attempts. Two of the participants were confident that they have the skills to prevent future lethality periods whereas two of the participants could not predict a suicide-free future despite an increase in coping skills, although both said that the risk of becoming suicidal again is lower.

Five of the participants reported diagnoses on the depression spectrum, with two reporting a bipolar disorder and three reporting clinical depression. One participant reported that she was diagnosed with a personality disorder. Participants had various lengths of psychotherapy with an average of four years of psychotherapy with a psychologist, psychiatrist, social worker, or other type of therapist. For some participants psychotherapy was spread out over a large span of time. For others it was confined to a specific period of time. All participants reported having at least one successful psychotherapy experience. During the suicidal period, four of the participants were single, three of the participants were married, and one participant was in the process of separation and divorce.

Part of the justification for interviewing participants after they are no longer considered at high risk of suicide is that their perception of reality is clouded during the time they are suicidal. Although this *clouded* reality is excellent information in itself, it limits the potential sense making of the experience by the participant. The other reason for waiting until after suicide risk lowers is an ethical matter. Participation in research during crisis may exacerbate the suicidal risk.

Data Collection. Clearly, some aspects of emotions are observable, such as crying and displays of anger. However, many emotions happen without visual cues and may only be assumed by the therapist or the researcher. Qualitative methods validate those assumptions by endorsing personal descriptions and explanations of suicidal person's emotional experiences. Although knowledge is not always obtained in an interpretive sense, attempts can be made at trying to understand something that one has not physically and emotionally experienced by organizing and comparing ongoing and reflective accounts of the experience of the individuals experiencing the phenomena. As a result, the methods chosen involve personal descriptions of suicidal clients' emotional experiences. There were three components of data collection: Interview, participant data, and follow up interviews.

Multiple and complementary sources of data were collected from participants. These multiple sources consisted of initial and reflective accounts. These different sources of data are complimentary in the sense that the diaries contributed immediate experiences whereas interviews contributed reflections about the person's emotions at the time he/she was feeling suicidal. There is no doubt that reflections about one's suicidal experiences would stimulate new insight and understanding of that experience. As such, the interviews complemented a purer, more immediate phase of that experience found in the diaries.

Initial accounts were collected by an invitation to participants to share nonprofessional data, such as diaries, poems, stories, or music from the time that they were suicidal. Four participants provided diary entries from the time that they were suicidal. Diary contributions from each of the four contributors ranged from one diary to ten diaries spanning the time that they were suicidal. Two participants alerted me to specific entries in their diaries, indicating that the diaries had become a stimulus for recollection. The remaining two diary contributors had not reviewed their diaries prior to the interview. Reflective accounts were collected in in-depth interviews and follow-up interviews with six participants. In-depth interviews were conducted in person. Follow-up interviews were conducted by phone, e-mail, and in person. Two of the participants were not reachable for follow-up interviews. Four participants were contacted by phone, two participated in one follow-up interview (in person and phone respectively), one participated in two follow-up phone interviews, and one participated in three follow-up phone interviews. Follow-up interviews ranged from five minutes to 40 minutes. The remaining two participants were contacted by e-mail with correspondence ranging from one to two entries ranging from a few lines to a couple of pages. The purpose of this use of diaries was to augment reflective accounts.

It is my assumption that the same factors guiding disclosure in psychotherapy (Rennie, 1994), guide disclosure in research and so care was taken to provide a safe, non-judgmental, and empathic environment. During initial interviews, care was taken to ask general questions so as to allow the participant to lead the way. Throughout the process, I presented the emerging design to participants and I sought their feedback in clarifying the meaning of dialogue. The ongoing nature of the involvement of participants allowed for a research relationship to develop, which, it is hoped, in turn facilitated disclosure.

Rennie (1992) presents the possibility that the participants' account seems to be their analyses or appraisal of what happened as opposed to their experience. Rennie labelled this phenomenon *client reflexivity*. My intention was to access how the client made sense of their experiences, while accessing the emotional process of being suicidal. Access to this subjective experience is essential where subjective experience is central to understanding the process.

Procedure. The data collection and analysis process emerged as a parallel process of meaning making, both on my part and on the part of the participants. The process spurred thoughts and inquires about how people make sense of their world. Upon initial contact, I informed each potential participant about the nature and purpose of the research, the time commitment required for the study, the interviewing process, confidentiality, informed consent, the participants' right to withdraw from the study without prejudice at any time, and the security of data. Participants who met the selection criteria and who were interested in the study provided demographic information about themselves, their attempts, and their psychotherapy experiences, prior to beginning the interview. Consent forms, a written description of the nature of the study, and participant rights were discussed and I provided a copy of these forms to each participant (see Appendixes C & D). Participants were reminded that there is no right or wrong answers and that one could stop without prejudice at any time. At all stages I provided opportunity for participants to ask questions. I assessed the participant's agreement to begin the interview and two audiocassette recorders were activated in order to ensure temporary preservation of the interview. Throughout this process, I paid attention to establishing rapport with the participants in order to facilitate their expression of genuine descriptions of their experiences (Osborne, 1990).

I began the initial interviews by asking about the individual's psychotherapy and eventually moved into specific questions about the client's emotional experience (see Appendix E). Shneidman (1996) suggests that asking *Where do you hurt?* prompts the individual about their emotions, feelings, worries, and psychological pain. This question was transformed into the past tense (*Where did you hurt*?) in order to access participant's conceptualization of that experience. Other variations included *Tell me about what it was like to hurt.* Additional questions were asked of each participant and encompassed important aspects of the phenomenon, such as associated behaviours and thoughts. I took care to avoid double-barreled and unclear questions.

Additional questions evolved out of the process of gathering data and were used in subsequent interviews. For example, it became clear that it was easier to ask a more general question about suicidal experience and move into questions regarding the emotional process (e.g., *What is important for you to tell me about your suicidal experience?).* Moreover, the participants focused on their emotional processes in general, and it became clear that "emotional processes in therapy" was too specific for this research. Participants found it difficult to separate their emotional experiences in psychotherapy from the overall emotional process. The flexibility of grounded theory allowed me to follow participants in this regard. Eventually, the emphasis on emotional experiences outside of psychotherapy became the focus of the study. Thus, the interview questions were used as a guide only (Appendix E).

Interviews lasted between 45 and 90 minutes. They were terminated when the questions were completed and the participant began to repeat herself or himself. At the end of the interview, I invited the participant to share other data such as diaries, poems, stories, or music from the time that they were at high risk of suicide in order to augment reflective accounts (see Appendix F). I sought permission to contact the interviewee for additional interviews at this time and contact information was shared. The participant was asked if they wished to be sent a summary of the results. This information and a mailing address were recorded.

During data analysis, a meeting was offered to assess the descriptions of their emotional experience in psychotherapy, to check for violations of confidentiality, to add any part of their experience that was not already attested to, and to make changes as needed. Participants who were agreeable to this follow-up interview were contacted, sometimes several times by phone or e-mail during data analyses. This component was included to enhance the credibility and trustworthiness of my description of the participant's emotional experience (Guba & Lincoln, 1989). Six of the original informants were available and willing to do this follow-up interview.

Six of the eight participants were available to participate in follow-up interviews. During follow-up interviews, the parameters of confidentiality were reviewed and agreed upon with participants. Many of them took the opportunity to reflect on the research process. Those five participants offered comments attesting to the helpfulness of the interviews in heightening their understanding of what they had been through. These follow-up interviews proved to be an essential stage of analysis from my perspective. It is through these follow-up interviews that I can present the results in the next chapter with confidence.

Data Analysis

Theoretical sampling and the constant comparative approach guided data analysis. Theoretical sampling is a sampling method of grounded theory based in the constant comparative cycle of using acquired data to narrow the focus of gathering subsequent data and analysis. Essentially, it is a process of eliciting codes from data and using those codes to inform further data collection, which help to further develop theoretical codes, until the codes have reached a saturation point (Glaser, 1978). The constant comparative approach to analysis is a method with deep roots in grounded theory. It is a process of comparing incident with incident, incident with concepts, and concepts with concepts. It is a process of constantly comparing similarities and differences, and general relationships within and between transcripts and other data during analysis in order to access the process.

In grounded theory methods of analysis, the data analysis runs concurrently with data collection and it continues until the point of saturation. The analysis began during the interviewing stage using Strauss and Corbin's (1990) highly structured procedures. I attempted an initial analysis and categorization after the first interview to inform and refine the art of asking questions in subsequent interviews. However, this procedure proved arduous and forceful of dimensions and properties. The analysis switched to a combination of Glaser's (1992) emphasis on traditional constant comparison and the generation of broader categories in the beginning stages of analysis. As such, the analysis was comprised of extracting higher level categories from the data without generating endless possibilities of concepts, categories, dimensions, and properties. Of course, the flexibility of the analysis allowed for constant refinement of categories and concepts. This approach is consistent with my intent to understand a process rather than generate theory.

The data analysis reflected the use of theoretical sensitivity. Theoretical sensitivity is the "ability to recognize what is important in data and to give it meaning" (Strauss & Corbin, 1990, p. 46). As suggested by Strauss and Corbin, I used the following techniques to enhance theoretical sensitivity during the coding process:

1. Attending to unrelated grounded theory research literature to minimize the influence of preconceived ideas.
2. Listing all possible meanings of a phrase or sentence to guard against biases.
3. Viewing the data from the opposite extreme of a dimension than what was reported to allow comparisons.
4. Employing the use of memos to keep an analytic record of hypotheses and to track and guide assumptions (Rennie, Phillips, & Quartaro, 1988).
5. Employing the use of questioning of the data: who, what, when, where, why, and how. Of the data I continually asked myself "What category or property of a category does this incident indicate?" (Glaser, 1992, p. 19).

As mentioned above, memoing accompanied the entire research process. This involved writing memos about emerging concepts and categories, the interviewing process, the literature, and any other aspects of the research. Memos were labelled to allow for subsequent sorting. Initially, I kept the memoing process separate from the data and I eventually incorporated the memos and the data in the constant comparative analysis.

The procedural steps that follow summarize the use of grounded theory method of analysis (Glaser, 1992; Glaser & Strauss, 1967; Strauss, 1987; Strauss & Corbin, 1990) in this study:

1. Transcribing the entirety of the first interview.
2. Open Coding: line-by-line process of open coding of the first interview and until the core category emerged:

   2.1. Examining the parts of the interview, labelling the phenomenon, and comparing incidents so that similar phenomenon can be given the same name.
   2.2. Categorizing concepts by grouping those pertaining to the same phenomena. Assigning more abstract names to categories based on technical literature or *in vivo* codes (words used by the participant) (Glaser, 1992).
3. Establishing and understanding relationships between categories and subcategories using properties and dimensions.
4. Selective Coding: Transcription and analysis of subsequent interviews followed principles of theoretical sampling described earlier. Categories were integrated to explain the emotional process at a higher level of abstraction. Coding was limited to variables that related to the core category. This involved the non-linear sequence of the following steps:
   4.1. Explicating a process that identifies the central phenomenon and leaves the remaining categories as subsidiary categories. Eventually this process illuminated the emotional process of being suicidal, that indicated change in conditions and the consequences of these changes.
   4.2. Validating the above relationships with the data - reconciling with the data.
   4.3. Developing and refining categories;
5. Memo Sorting: The memos generated from this process were sorted according to emerging concepts and categories, into a model, according to similarities and differences and other comparisons. This process generated additional memos, which helped to further understand the phenomena.

Credibility

The credibility of grounded research begins with following specific techniques at each stage of analysis, which have already been described:

theoretical sampling, open and selective coding, theoretical sensitivity, and constant comparative analysis. These techniques ensure a process that is grounded in participants' experiences, and therefore the findings are credible. Beyond this scope, future studies may address hypotheses created by the categories identified herein and in doing so may build upon the scope of this research. Such studies may attempt to replicate this research for validation purposes. The issue of applicability of theory to different situations is not relevant in this research because it was not my intent to generate formal theory. Rather, internal validation with the data is the primary illustration of credibility.

Credibility is further conveyed with quotes (Glaser & Strauss, 1967) directly from interviews and diaries and also by the description of the analysis, which allows the reader to judge credibility independently. In this respect, a readers' judgment of credibility may be observed in his or her reaction to the presentation of the results and his or her assessment of how the researcher came to her conclusions, whether it be flat or convincing (Glaser & Strauss).

Hermeneutics is a theoretical approach that asks, "What are the conditions under which a human act took place or a product was produced that makes it possible to interpret its meanings?" (Patton, 1990, p. 84). Here, hermeneutics relates to the various interpretative perspectives involved in the data-gathering process of understanding the emotional process of being suicidal, including, the ongoing disclosure decisions of participants, the influence of my questions and what data are followed up upon, and the influence of my interpretation of the data. The recognition of hermeneutics in grounded theory methods and in all other approaches to qualitative research (Rennie, 2000) has direct implications for judging credibility. These influences are somewhat remedied via follow-up interviews with participants, the constant comparative analysis of the meaning of data with other meaning units, and through the process of acknowledging hunches in memoing and bracketing. The research goes beyond identifying perspectives by using analysis to create "explanatory schemes" which are grounded in real-life experiences (Henwood & Pidgeon, 2003).

Despite intentions to let theory emerge from data, the level of interpretation required in analyzing and communicating results cannot be ignored. Bracketing is a "means of demonstrating the validity of data collection and analytic processes" (Ahern, 1999, p. 407). While accepting that total objectivity is not virtually possible, nor desirable in qualitative research, several steps were taken to ensure that analysis and results stayed true to the participants' experiences. Many of these strategies were already discussed in the context of grounded research procedures. Consistent attempts were made to reduce the influence of preconceived notions and ideas of the organization the data suggests.

A specific issue that arose during this process of self-evaluation concerned the chronicity of suicide ideation. I found myself focusing on the seemingly long-term nature of suicidal thoughts and feelings. It seemed that some participants were describing a chronic state of suicidality with acute peaks that led to suicidal behaviour. I checked this assumption with many of the participants. They described varying lengths of being suicidal, with some describing their process as an ongoing state whereas others described it as more acute with resolution in a short time.

Ethical Considerations

Permission to conduct this research was granted by the Faculties of Education and Extension Research Ethics Board in December 2001. Ethical procedures for psychological research involving human subjects (e.g., informed consent, confidentiality, and rights of participants, security of data) were followed in this study. These have already been outlined in the procedure.

As the subject matter of suicide and emotional experience could have evoked some discomfort for participants, I was prepared to offer support and referrals to participants. Participants were advised of the minimal risk of discomfort in remembering the time that they were suicidal and in remembering specific emotion episodes. They were encouraged to keep me informed should discomfort occur so that support and referral could be provided and care was taken to check their comfort level during interviews. Participants were informed of these issues prior to their participation. Many of the participants had ongoing contact with a mental health professional and thus declined the referral.

The following steps were taken to protect the confidentiality and anonymity of the participant. Records and transcripts were stored in a secure location. Pseudonyms replaced actual names and any other identifying information was altered in the transcripts. Participants were informed of these measures.

Summary of Method

This chapter presented the use of grounded theory methods of analyses in investigating the emotional process of being suicidal, within a qualitative paradigm. The analysis began during the interviewing stage using Strauss & Corbin's (1990) highly structured procedures. An initial analysis and categorization was attempted after the first interview and was used to inform and refine the art of asking questions in subsequent interviews. Again, this procedure proved arduous and forceful of dimensions and properties. The analysis evolved into a combination of Glaser's (1992) emphasis on traditional constant comparison and the construction of broader categories in the beginning stages of analysis. As such, the analysis comprised of pulling out higher level categories from the data without generating endless possibilities of concepts, categories, dimensions, and properties. This approach was consistent with my intent to describe a process rather than generate theory. The results from this analysis are presented in the following chapter.

Chapter Four

Results

I don't want to die; I just don't want to live.

The following is a presentation of the emotional process of being suicidal, from the perspective of clients who have had psychotherapy. These results suggest that the emotional process of being suicidal has many complex and interacting components. All of these components represent a continuum of experiences that relate to one main theme during the entire process. That main theme is the person's developing awareness of his or her emotional process. This process comprised of three stages, *Compressing, Blocking,* and *Allowing* emotions. Participants reported experiencing these stages of emotional awareness in four main emotions, *Powerlessness, Despair, Isolation*, and *Fear*.

None of the excerpts presented here is intended to be a diagnostic tool for assessing the extent of awareness a suicidal person has about his or her emotions. Rather, practitioners should keep in mind that each person has an individual threshold of endurance for emotions and their growing awareness is relative to the amount of awareness one had when they began to feel suicidal.

Many different levels of interpretation are evident in these results. Among them includes my interpretation of participants' experiences, participants' interpretations of their own experiences, and the influence of questions on the direction that participants' took in sharing their experiences. The interaction of these levels of interpretation influences the nature of the data collected. In the presentation of the results, I will clarify whether a category is primarily based on my interpretation or on the participant's interpretation. Generally, the core category, *Developing Emotional Awareness*, views the experiences from my interpretive lens whereas the other categories were emphasized from the participant's lens. I reviewed the emerging design with participants throughout and revised accordingly.

The difference between diary and interview data and both levels of awareness in the core category is a matter of salience. Generally, the material in the diaries provided accounts of highly lethal periods, as well as periods before and after high lethality. The material collected during interviews reflected non-lethality periods. However, these periods were inevitably marked with new constructions. Hence the differentiation is better captured in terms of growing awareness as opposed to diary versus interview.

The process of making meaning for participants cannot be ignored in considering the results. It is difficult to differentiate acts of reflection from acts of construction. As such, the level of social construction changes throughout (Martin & Thompson, 2003). Many of the participants said that the interviewing process fostered a new level of understanding that was helpful. During the follow-up interviews, many reported realizing how far they had come in recovery. They attributed this realization to the opportunity to describe and process their experiences.

Developing Emotional Awareness

The core category, Developing Emotional Awareness, emerged as being central to understanding the emotional process of being suicidal. It was present at all times in the data and it accounted for much individual variation in the remaining categories. In this respect, it seems to be the primary vehicle in the process. In fact, this developing awareness may be the key to understanding participants' development of better coping skills, which inevitably influences lethality. As such, awareness of one's emotional process captures the meaning inherent in all other categories.

There was a shift in one's emotional awareness throughout the suicidal process. This process of change in participants' awareness of their emotions may be understood on an awareness continuum. The beginning of the continuum represents whatever level of awareness is apparent as the person begins to feel suicidal (see Figure 1). The awareness at the beginning of the suicidal period was termed *Initial Emotional Awareness*. Over time, participants' experiences evolved into a relatively more integrative awareness of one's emotions, represented most concretely by a relative increase in coping skills. This *Integrative Emotional Awareness* consisted of participant's growing insight and perspective into the process. As with any continuum, it is difficult to say where initial awareness turned into integrative awareness. Rather, the more important idea is to realize that emotional awareness evolved and developed throughout the process of being suicidal and thereafter. The quality of awareness was variable among participants and at different stages of the process. It is less important to notice the level of sophistication of awareness than it is to notice how awareness developed for individual participants and how they gained more control over this self-awareness. It is the quality and sophistication of insight and awareness that changed along the awareness continuum. In fact, it may be this awareness vehicle that allowed the development of new coping capabilities that in turn may have facilitated reduced lethality levels. One or multiple suicide attempts occurred along the continuum.

Three stages of Emotional Awareness exist along the awareness continuum, Compressing emotions, Blocking emotions, and Allowing emotions. Emotions that participants talked about consistently included Powerlessness, Despair, Isolation, and Fear. All of these emotions went through all the stages repeatedly as emotional awareness was developing (see Table 1). So for each and sometimes multiple emotions, participants went through a process of being overwhelmed by the emotion(s) to the point that they would consciously or unconsciously block the emotion(s) until they felt able to allow the emotion(s) back into awareness to be dealt with. This process was repeated continuously, slow at first, then faster as participants gained more control over how to use the different stages to work through the emotions. As such, participants seemed to be learning a form of emotional intelligence, including emotion regulation. The emotional process described in these participants' stories comprised of cycling through different stages of awareness of emotions and all the while learning coping skills in order to regulate those emotions more efficiently. The stages were experienced at less intense levels as the coping repertoire was broadened. In other words, as participants gained insight into their circumstances, the cycles were more spread out and speedier, relative to previous slower- moving cycles, suggesting that participants were able to utilize growing skills to work through each of the stages in a way that facilitated the process of lowering lethality levels.

The stages mirror themselves along the continuum from initial to integrative awareness to illustrate that a participant can move through the stages repeatedly (see Figure 1). In other words, the participants went through the stages of Compressing, Blocking, and Allowing emotions during periods of high lethality and during the time that they had integrated awareness and coping skills to reduce lethality. As such, the stages were experienced as less intense further down the continuum. Although these three stages usually occurred in the order that they are presented, the transition from one stage to the next was often blurred and participants frequently bounced back and forth between Compressing and Blocking and also between Blocking and Allowing, until skills were sufficiently developed to safely allow emotions into awareness to be dealt with.

Table 1

Emotional Process of Being Suicidal: Awareness Thematic Structure

Main Theme	Stages of Awareness	Suicidal Emotions
Developing Emotional Awareness	Compressing	Powerlessness
Initial Emotional Awareness	Blocking	Despair
Integrative Emotional Awareness	Allowing	Isolation
		Fear

Initial Emotional Awareness.

> The diaries were all dark, not happy, no real feeling, all negative thoughts, lack of understanding that made them so dark.

Initial Emotional Awareness consists of participants' awareness of their emotions when they begin to feel suicidal and spans periods of high lethality when participants attempted suicide. Evidence of this level was primarily found in the diaries, which provided ongoing and daily accounts of emotional processes, emotional experiences, and perceptions of those experiences. This level primarily involved my interpretation of the process and it was confirmed in follow-up interviews. The three stages of awareness, Compressing, Blocking, and Allowing emotions, are evident with Initial Awareness and will be discussed in the context of those stages.

Integrative Emotional Awareness.

> Where I was then and where I am now are totally different.

Participants' perceptions of their circumstances seem to change and evolve considerably as they went through the stages of awareness. Integrative Emotional Awareness represents this more developed emotional awareness. Evidence of this process was mainly derived from the interviews and participants' reflections on diary entries, "Span of about six months that I don't remember; the diaries are my memory", which provided integrative accounts of the emotional process of being suicidal. This integrative level represented insight over the entire process. In many cases, clouded perceptions during suicidal periods were clearer in retrospect. For example, a different, more realistic lens ("I know now that they were worried, that they cared.") of perceived support replaces the idea that certain support persons were unhelpful or not supportive. The participant who wrote in her diaries that her views were clouded, ("My eyes are growing dim from my clouded views"), described having the ability to make sense of her experience through her awareness and acknowledgement of emotional pain, in the interview.

One of the main differences between initial awareness and integrative awareness is how the actual suicide attempt was understood. Surviving a suicide attempt at the time was described by one participant as an "unsuccessful attempt", whereas, after the suicidal period, the attempt was described as a "successful failure", thereby representing a shift in meaning.

The most important aspect of Integrative Emotional Awareness is the increase in coping skills that this growing awareness represents. Coping is the marker that differentiates initial from integrative awareness. Participants' awareness of those coping skills and the impact of that awareness on minimizing the risk of future suicidal episodes is the key to understanding the role of awareness in the emotional process. "I'm more prepared for the future and if it ever surfaces again, I'll be open to different ways of dealing with it." Some examples of coping skills identified by participants included increased problem-solving skills, reserving the option of suicide to prolong life, and the ability to control the intensity of emotion.

Stages of Awareness

The stages of awareness are Compressing, Blocking, and Allowing emotions. They will be discussed in the context of the participants' movement from Initial Emotional Awareness when first suicidal to Integrative Emotional Awareness, when coping skills are better established. To facilitate understanding, each stage will be defined and excerpts of that stage at beginning and end of the process of being suicidal will be presented to show how the emotions are experienced with the development of better coping skills. Awareness is relative to the individual so these excerpts should be used for illustrative purposes and not as a diagnostic tool.

Compressing.

Underneath it was all just boiling. It's like this lava that's just waiting to

> erupt and come to the top... And um, I could not live like that - I had enough. I could not live like that anymore... Not knowing enough to reach out. But the emotional pain – it's a feeling of terror, shame, foreboding, and like, there's an emergency but you're tied down and not allowed to scream.

The compressing stage represents a state of feeling overwhelmed. It consists of the experience of single or, more usually, multiple stressors and emotions at intense levels.

> Mental collapse due to stress is what the doctor said. What does she know? It's more uncontrollable blowing up and outward than collapsing inward.

The key to understanding the compressing stage lies in the notion of threshold. Each participant had an individual threshold for managing emotional intensity. Overwhelming emotions reached beyond this threshold when the participants' perceived coping repertoire and ability to exert control did not match the demand.

> My heart and my mind are all jumbled. What is happening? I never felt like this before. I just don't know if I can take any more heavy stuff right now.

In keeping with the notion of threshold, it is important to emphasize that the type of stressors did not predict emotional turmoil. Rather, individuals reacted to similar stressors within a spectrum of variability. Sometimes stress that is considered minor to most people may be experienced as overwhelming by persons who have not been exposed to traumatic stress thus far in life. The opportunity to develop coping skills for those individuals may have been limited until now. For others, chronic stress was exhausting, despite available coping skills. Overall, the type of emotion-evoking stressors varied greatly across individuals. As such, an examination of the types and numbers of stressors is irrelevant and beyond the purpose and scope of this study. It is important to know that stress is relative.

One participant alerted me to the following diary excerpt in her experiencing of Compressing during discussions in a follow-up interview, "Life is horror...I am horror... I don't want to live and I cannot stand to be me." Another example of the Compressing stage includes,

> I was sure that this world could offer me nothing but constant... and I do mean relentless pain. I was contaminated by it, huge pain. If you were to cut someone's heart out it wouldn't hurt more.

For the remainder of this document, the term *Compressing* refers to high levels of practical and emotional stress that causes overwhelming feelings when reaching a threshold of endurance.

The range of awareness in the Compressing stage was variable. This range is represented by developing emotional awareness, on a continuum of initial to integrative emotional awareness. An inexperienced suicidal participant attributed compression to the stressors he reported, "I just let everything pile up for way too long, with events happening too fast and too close together." For him, this initial stage of emotional awareness was marked by an inability to identify emotions. Stress was attributed to concrete events instead of the emotions that those events provoke. So, the awareness is more on the effect of the emotion(s) as described in these metaphors, "It just feels as if my whole world is crashing down and I have no shield. It just feels like I'm being sucked down the toilet of life." This overwhelming state is eventually acknowledged, "I can recognize it now. Its unbearable anger and sadness and underneath it all, fear of something, I don't know what of."

> I didn't know how much more I could take and I knew I was at my breaking point. I knew that if I felt any worse I would need to end it so that's why I needed the gun... I wasn't going to try to OD on pills or

> anything like that. If I did it, it was going to be final. I didn't want to be resuscitated. It was um, in that space, but I realized I was at my limit and didn't know how much longer I could take it.

The emotional impact of those emotions was appreciated by this participant towards the integrative level where coping skills are demonstrated. In many cases this awareness developed during reflections of Compressing.

> Looking back I can see that it was my perceptions of how it was that was wrecked. I can think of 10 different things to do now. It's just a matter of realizing those things when I'm in that state. There's not really anything different about my life on the outside now – same problems. It's just that now, I'm more comfortable with the ambiguousness of life.

This particular coping strategy involved using perspective-building to increase tolerance for compressing emotions. It is important to note that the type of stressor(s) does not necessarily change throughout the process from initial to integrative awareness. Rather, coping changes as a result of this integration and perspective building. The main difference with reflective accounts of compressing is the increase in awareness and insight of the compressing process.

Blocking.

> I wanted to live in a stage of at least neutrality or numbness if I could never be happy again – This would at least be tolerable.

When the intensity of emotion reaches the threshold of endurance, a number of things may happen, all of which involve a means of gaining relief from the emotions. This relief is evident in the blocking stage of emotional awareness. It involves blocking emotions from consciousness by denying, avoiding, ignoring, or covering up overwhelming feelings and it also consists of suicide attempts, "I don't want to die; I just don't want to live. It was a way to end the pain, not just escape from it". It is a withdrawal state that functions as a control gear on emotions, whether or not the individual is aware of its presence.

At the initial emotional awareness side of the continuum, some describe Blocking but they seem unaware of their own blocking. The nature of their comments is more indicative of the presence of blocking emotions, "I haven't cried because I can't. I'm just getting more and more withdrawn." "I don't feel anything. I just feel nothing." "I am closed. Why do I do it?" This particular example indicates that the person is aware of feeling nothing but the participant does not know or speculate the presence or function of feeling nothing. It represents description of experience as opposed to understanding experience. This type of blockage seems to be an automatic protective mechanism against overwhelming feelings. The following excerpt also illustrates minimal awareness of the blocking mechanism.

> Time has no meaning. No hunger pains hurt me. A dull shadow over my face. No smile on my lips. I don't feel like anything. I just feel nothing. I eat cause I have to. I read so not to be bored. I blink every minute. I breathe in and out. I'm not hungry. I'm not bored. I'm not sick. I don't know what's wrong.

This next excerpt shows acknowledgement of Blocking. It also shows the ability of the blocking mechanism to block, not only difficult emotions, but most other emotions as well, "I can't seem to feel anything, good or bad, except that I can feel myself retreating." The same participant acknowledged her ability to use the blocking function in a later excerpt, "I'm doing it again!" As her awareness of this blocking stage increased she further acknowledged the use of blocking and when she needed to use it, "I want to hide. That's what I normally do when things get hot. I just want to forget everything." Although blocking has a consistent presence following the threshold of emotional compression, it is not isolated to the period of time following compression. Again, participants frequently bounced back and forth between Blocking and Allowing, as they attempted to incorporate new coping skills. This backwards/forwards direction of the stages decreased, then, as integrative awareness developed. For the remainder of the results, the term *blocking* will be used to represent this covering, suppressing, or ignoring of intense emotion.

Blocking can function either to allow or stall a suicide attempt. With respect to the former, blocking seemed to function as relief from emotional pain and also for protection against pain, "The pain in my arm will numb the pain in my heart and my head." "I was definitely not wanting death so much as I was desperate for relief from pain."

> Suicide is like a craving for a cigarette. I know it's not good for me but I still want it in order to feel relief. I know the urge will go away in a short period of time. The cravings will always be there.

Otherwise, the Blocking of emotions seemed to function to stall the attempt, "Sometimes I have to make myself numb and be ambivalent about things in order not to do it." In both cases, it became an internal protective factor against the threat of emotions intensifying or continuing beyond the threshold.

The transition from compressing to blocking emotions is closely tied to individual thresholds. There is much variability in individual thresholds, which may parallel the individual variability in the type of stress that contributed to overwhelming feelings. The transition to blocking emotional pain begins with an appraisal of the need for relief from compressed emotions and/or stressors. The following excerpts illustrate the transition to blocking emotional pain. "Sometimes if I think about it too much, it won't go away." "I want to go away and hide. I don't want to think and I know its better that way. I feel numb." "I'm tired of fighting. I'm tired." In fact, the internal conflict presents a need for blockage from two standpoints, the conflict itself and the struggle to block the conflict.

> Part of me wants to come and learn about myself and learn how to be a happy person. Another part of me doesn't want to have to examine

> myself. So there are these two electrical charges fighting one another, creating so much tension that I want to stop both the internal crap and the struggle to stop the internal crap.

As the participants went through the process repeatedly, they seemed to become more aware of the healthy function of blocking. This Integrative Awareness allowed them to gain some control over the blocking, "I feel very numb and that's safe." This control, developed to some extent in all participants, acted as a coping mechanism which allowed them to filter the amount of emotional pain that they could safely deal with at any time, until other coping mechanisms were established. This more sophisticated level of awareness is reflected in this participants' ability to analyze the influences of the Blocking, "I don't really know if there is anything out there that I'm afraid that I'm still trying to shut out or whether it's just that its so nice in here." "Between a rock and a hard place - feeling or not being?" These excerpts reflect awareness of the Blocking and acknowledge the safety function, the questioning of the Blocking, and the realization that one cannot block and feel at the same time. However, they may not know what to do with this awareness:

> When it gets too hard I just run away from the pain, in my mind and my heart. I don't seem to know what to do with it. I can acknowledge it exists but I just don't know what to do.

This acknowledgement in itself is a sign of improved coping in that the blocking is recognized as having a function in the context of stress.

Towards integration of awareness, participants' awareness of the Blocking stage had developed relative to their experience of blocking while suicidal. One participant realized her obliviousness of positive things that happened during the high lethality period.

> Feeling suicidal? I would just say a big black hole. It's really about being so empty that it hurts more than living. The emotional pain was too much

> for me to handle so I had to transfer it to physical pain. I would get to a point where I couldn't feel the pain, more of numbness with a very subtle disturbing emotion at the core, not of my body but my being. I can't name the emotion. It wasn't guilt or shame. It shuts down everything, even what one desperately wants to feel. The feeling pops into my head but just as quickly I am able to put it away.

Some participants made an important distinction with respect to the function of Blocking in a suicide attempt. They emphasized that they were not seeking death. Rather, they were seeking and needing relief from life and all things in life that pushed them beyond a reasonable threshold of emotional pain. As such, suicide was not seen as death, per se. Rather, suicide was seen as relief from life. The following excerpts further illustrate this distinction. "I don't want to die; I just don't want to live." "I don't want to die but I want it all to end." "I don't want to die; I just want to sleep for a long time." "Basically I've come to a standstill and I am going around in circles again. Where is the door?" "They shoot animals when they are in too much pain. I wish they would shoot me." "I wanted to go somewhere - the other side of the door where the pain is more bearable."

> I wasn't particularly anxious to die, that's all. I wasn't in love with death. You know, it's a big mystery too. It's a very scary thing when you're in that place to just say, what will happen to me after I pull the trigger? I hated living. It was just painful. Every second that ticked by was excruciating. It was just torture just to be alive.

Blocking moments of relief from intense emotions could happen at anytime in the cycle. Participants in this study described these moments following a suicide attempt, emotional release, or physical separation from compression. In cases described herein, the relief was short-lived. "It's like a day night switch after I had this total flood of everything out of my system." "Going on that long trip and being in the middle of nowhere snapped me out of it." In some cases the snap or moment of relief from emotions provided a dose of reality which, in turn, fueled a return to the Compressing stage, "After the attempt I snapped out of it and felt good as new. Well, not at first because I was sick from the pills. Then the gradual slide downwards again - it was inevitable to the point where I kind of expected it."

Probably the most consistent theme with regard to growing awareness along the process is participants' awareness and impression of their support network and how that influences coping. Generally, support was underestimated during periods of high lethality and realized at the integrative stage, "I couldn't see those who were trying to help me as helping." "Nobody was concerned even though I know now that everybody was concerned about me and everybody was trying to figure out why I was acting the way I was."

Allowing. The loosening grip of Blocking allowed emotions back to awareness. Some participants described a reality-based awareness that allowed them to realize the extent of their emotional compression and the need to block threatening feelings. Each participant had some sense of this awareness of circumstances and feelings. Participants who previously questioned their reaction to stressors were now acutely aware of their limited ability to cope with these stressors:

> Now, I'm working on my feeling my reaction to my memories and exploring them. I am allowing it - I am learning to give myself permission to feel my emotions.

Some described it as a conscious transition and others were oblivious to the change. "I guess I'm starting to feel again because I'm starting to notice my need for a bath". "Each day seems painful but that's because I'm finally beginning to feel alive again." "I have been suicidal for a long time now but I've been in denial. I am tired of being lost." This awareness led to a release of emotions, with the type of releasing ranging from tears in a counselling session, to finding the ability to write and talk about painful events or feelings, to actual suicide attempts.

> Today was the day I turned over a new leaf. I had whatever you call it mental/physical/emotional breakdown. It was the weirdest feeling ever. I couldn't stop crying for hours straight. Life went on from there.

Some were blatantly aware of this happening. Sometimes the level of allowing emotions was overwhelming, bringing on the compression stage in too short a time, without relief, "Do it! Get it over with! Gone! Done! And then you can go on."

Generally, from an integrative perspective, participants expressed shock at suicidal periods, in retrospect, and this awareness led to a quality of self-validation of the difficulty of being suicidal, "I can't believe how messed up I was... re-reading some of my stuff, its just plain scary shit. I hope I never get that depressed again." Some were aware of moving from Compressing emotions to Blocking emotions to Allowing emotions but they were not aware of how to stop those cycles. Those who were generally more aware of the process seemed to be those who experienced the process repeatedly. It was after this awareness of repetition that an element of control over the process began to develop, "To feel it all once again doesn't give me the power to erase it just yet. It does help me to see how I react to things now."

Towards the integrative end of the awareness continuum, Allowing represented the person's ability to see the entire process from a more realistic lens. Their reflections on the process also implied an appreciation of the suicide struggles with respect to acknowledging developments in current functioning. For example, this next excerpt illustrates the participant's awareness of triggers and the coping strategy of staying in a safe place while suicidal. The participant's awareness also represents learning and insight into the importance of taking action when the next suicidal phase happens.

> I was very lucky to go through those feelings. Realizing that I can still have triggers and catching it before it gets out of hand. The best way to cope with it is to stay in an environment that is completely safe, and not drive... Your brain is somewhere else. It usually passes. Knowing that I can go through that again is a real shocker to me... It was a real eye-opener... If I'm at that stage and someone triggers something, I know I will go down that avenue if I don't do something about it.

The Allowing stage of Integrative Awareness also captures specific aspects of the process. For example, the following is a retrospective account of the transition from Blocking to Allowing emotions, "But um, then the questions came. Then I could think and feel. And that's when the despair really set in. I could think but I still wasn't thinking straight." Also the awareness of the transition from Blocking to Allowing emotions is evident in retrospective accounts. This transitional awareness is another type of coping, one which has the same goal in mind, relieving any pain and preventing future pain:

> Well, you're very lethargic - like somebody sucked all the energy right out of you. After coming out of that stage you get more energy and then you start thinking about things, usually about how to end things and prevent the hurt from creeping up again.

An awareness of the increase in coping skills is evident in new perspectives.

> Each time I cycled through surviving attempts I learned a new coping skill, which helped with the next one. The major shift now is that I'm at peace with who I am and I didn't have to die to get there.

The impact on coping is obvious, "Now I have trial period for new experiences to decrease disappointment of high expectations." "It was a resolution process, not an event."

The processes involved in reserving the option of suicide as a source of relief in the future are conceptualized as the Paradox of Suicide, "I know I can do it anytime so I might as well wait... helps me to keep going." This paradox is a protective function of permitting oneself to commit suicide if life became too intense. In other words, suicidal ideation provided a future option that gave participants permission to keep going for another hour or another day. This permission ensured a relief route, a coping mechanism, during the suicidal process and after the risk of suicide was lowered. The intent of the reservation of committing suicide functioned against suicide and instead prolonged life by holding off the attempt. In this respect, the chronic permission of suicide alleviated emotional pain, or at least made it more bearable because the person had control of the extinguisher. As one participant explained,

> Imagine being in a room and not being able to get out versus being in a room with all the doors open. Having the doors open provided the option of leaving, thus reducing the desire to leave.

This permission is different than the impulsive act and the planned suicide act. Instead of suicidal ideation with the intent of dying, it is a cognitive escape from the same emotional pain that contributed to suicidal ideation.

The following excerpts further illustrate the life-saving function of suicide ideation. "In a weird way, having the option has prolonged my life - it helped me to cope with the pain." "I counted the number of pills I have. I should get rid of them but I feel safer knowing that I have them." "And I know right now, I've got everything all organized. I've got my plan in place which helps me keep going." "It's sort of a like a comforting feeling."

Other participants spoke of this permission as "fuel" for the suicidal thoughts and feelings. They spoke of events that led to validation of their pain, which in turn gave them permission to feel the pain and justify the attempt, "Now I can delve into my suicidal thoughts. The fact that a celebrity did it gave me that initiative to stay in that mode and not try to get better." In many cases, participants' attitude changed throughout the process. For example, one participant saw suicide as an opportunity when emotional pain was intense and the same participant labeled suicide as an "escape, a cop out, giving up" after recovering from high lethality.

This cognitive dimension was particularly difficult for me to conceptualize. It is important to note that this permissive function of reserving the option of suicide does not necessarily protect oneself from the impulsive act, especially when the means are readily available in the context of being a life preserver. It would be a juggling act in therapy to deal with this paradox and the potential danger that it represents. I struggled with the notion that suicide ideation has a function that does not necessarily conform to socially constructed reality. Following several conversations with two participants and checking with other participants on the matter, I began to understand that suicide ideation does, in fact, play a role in keeping a person alive. Some of the participants were aware of the lethality of this "mind game" and others continue to be oblivious to its potential consequences.

Suicidal Emotions

The remaining categories consist of emotions common to these individuals during the time that they were suicidal: Powerlessness, Despair, Isolation, and Fear. These emotions may occur in nonsuicidal individuals; however, their intensity may be more specific to suicidal individuals. Also, the finding that all four emotions were experienced consistently in these individuals help to differentiate suicidal feelings from nonsuicidal feelings. They are captured here within the context of participants' evolving awareness of their emotional process. In each category, participants went through stages of the core category, Compressing, Blocking, and Allowing emotions along the continuum of Initial Emotional Awareness to Integrative Emotional Awareness. In this respect, each suicidal emotion is grounded in the core category, Developing

Emotional Awareness.

Suicidal feelings is synonymous with suicidal emotions in this document and refers to the experience of one or more of Powerlessness, Isolation, Despair, and Fear at unbearable levels that lead to the need to stop that emotion(s) from continuing at such intense levels. This threshold of endurance was different for each participant, of course. Not everyone has the same level of tolerance for emotional pain. One or more suicidal emotions may be evident at any one given time. For these participants, the suicidal emotions represented the painful feeling of being suicidal. As such, it was not the individual emotion that pushed one toward attempting suicide. Rather, it was the unbearable pain of having that emotion(s) that contributed to being suicidal.

Emotional pain is the feeling of being suicidal. It is not a specific emotion but an abstract conglomeration of emotions occurring during the suicidal period: Powerlessness, Despair, Isolation, and Fear. It includes emotions occurring during the compressing period and thereafter. Participants found it very difficult to describe the pain of being suicidal, although one person was very descriptive in defining it as a "very subtle disturbing emotion at the core, not of my body but my being. I can't name the emotion." Suicidal emotions were evident in different strengths along the process. These emotion categories consisted of the purest data from participants, indicating that participants spoke independently from the influence of my queries.

Powerlessness

Powerlessness represents the emotional continuum of perceived agency or control over emotions. It is closely linked to feelings of loss of control, feeling overwhelmed, and experiencing a sense of confusion. The function of Powerlessness changes throughout the suicidal process. It may surface as a loss of agency over emotions reaching the threshold or as a sense of powerlessness to stop one from hurting oneself. Control and agency were sought through self-mutilation, suicide attempts, alternate coping, or through external controls (e.g., outside interventions such as family or psychotherapy support). Powerlessness is further explained in the stages of awareness, Compressing, Blocking, and Allowing emotions.

Compressing. As emotions and stressors compress, participants' sense of emotional control decreases. In fact, participants spoke at length of feeling as if they were losing control in the Compressing stage. This emotion fed on participants' feeling that they had no power to exert control over their emotions. This loss of agency spilled over into feeling inadequate to carry on, "Sense of total confusion exists around me and I feel totally lost, groping around in the dark. I suppose it's a loss of control."

Clearly this loss of control impacted on their control over staying alive, with respect to impulsive and planned attempts. The following excerpts illustrate this perceived lack of control in Initial Emotional Awareness, "I don't know what I'd do if I had more pills." "I didn't have any responsibility because I didn't have any power. But I never ever um, was able to make that distinction." "A moment of mental clarity happened today. It consisted of a clear thought, uninhibited by feelings of self-doubt or mind wandering. But I've slipped and find myself falling into a negative pattern again." The following excerpt illustrates the integration of awareness of feelings of powerlessness in the Compressing stage, "I'm just beginning to realize how much of my life has been centered on control."

Blocking. The feeling of powerlessness to control emotions triggered the need to cover or suppress those emotions in order to reestablish a sense of control. Initially, participants described blocking emotions that threatened emotional equilibrium but they did not acknowledge that it was control that was sought. Participants' awareness of the presence of need for feeling in control eventually became apparent as they became aware of that need, "I can't control my feelings other than to stop them. It's easier, they're still there but I'm taking a break. Time Out." The following excerpt illustrates the use of Blocking to control emotions from reaching the threshold:

> After a while your lungs hurt so it feels good to breathe normally for a while so you don't pass out. I was always able to stop it if I felt like it before. I could just stop the feelings - I was in control of them in terms of having them or not. So once I did that I felt much better.

In the context of perceived lack of emotional control, some felt that ending the pain, or having the option and means to end the pain, re-established a sense of control. Again, this idea falls under the Paradox of Suicide. For example, some participants attributed the method of planning attempts to re-establishing a sense of control, "When you feel suicidal, you feel like you have control again." In this respect the participant had control over the option to end the pain. "I've got my pain in place which helps me keep going." "But the power to end it all was something I cherished... and it helped me get some space from the pain." This seems to be a contradiction with the sense of lack of control of being suicidal. However, participants clarified that both a sense of control and a sense of lack of control are operating when they feel suicidal. One participant mentioned that both types of control can happen in the same hour or for days at a time.

Allowing. Feelings of powerlessness rebound or flood out after blocking methods are exhausted, especially in the early stages when regulation skills are limited. The following excerpt illustrates the operation of the Allowing stage in a rebound of powerlessness at less intense levels, probably due to the releasing mechanism of Allowing emotions:

> I cried for days and didn't know how to make it stop. For hours. Had no control over it the entire time. Nobody knew what to do. It went on forever. I don't even remember how it stopped."

Once skills were developed via awareness of the presence of feelings of Powerlessness were tolerated, then transformed into more objective indicators of matters of concern to the participant. This transition is not clear but may involve mechanisms that alleviate the need for the protective function of blocking, such as psychotherapy or other forms of support. In this next excerpt, the stage of Allowing is evident in tolerating or transforming feelings of Powerlessness.

> My walls came down in therapy. That experience was as close to being suicidal - being present to those feelings but not being overwhelmed by them. Having control. Feeling of power that I was able to deal with it.

After surviving an attempt, new feelings of powerlessness over ending one's life may emerge. "I see it as a successful failure now, but at the time I just saw it as another failure." In some cases, this sense of lack of control is mediated by external control. "It's a good thing I promised Dr. X that I would hang in for another month. If I hadn't made that promise I don't think I'd be here." "A few days later when he came into the hospital and shook his finger at me and said you're not doing that again. And I felt much more comfortable."

The Allowing stage brought about a reduction in feelings of Powerlessness in other instances as well:

> I would write pages at a time and just writing things and I had so many thoughts that I couldn't get them on paper fast enough. No matter, if I didn't get them on paper it just is a release. It just feels like all my anger came out on paper so I didn't have to worry about it inside of me. It put me back in the driver's seat.

Re-establishment of feelings of agency is evident in the emerging ability to make healthy decisions, however insignificant those decisions may seem. "Tomorrow I have to call with my decision to go home from the hospital. I feel forced into saying no. I can see that I'm not well enough yet." In this excerpt the control of planning a suicide attempt transfers to other types of control over one's life. The transfer to a more realistic lens is realized towards the integrative side of the continuum as illustrated in the following excerpts, "Totally in control of my journey." "I can't decide my fate, the same as anyone else, but I can make choices to let my fate become more of a reality."

> It felt like a little bit of time or power. Like I can say now how other people being aware that you're suicidal giving you leverage... That had never been my intention but that was the very pleasant side effect... But anyway, it enabled me to have a certain amount of, to prioritize myself I guess... Just having that one experience with the suicidologist really helped, in terms of somebody telling my parents they're fucked in the head. It was what I was thinking all along.

The longevity of suicidal emotions varied among participants. This ranged from chronic to recurrent to acute forms of emotional pain. With respect to residual suicidality, participants emphasized that traces or shadows of being suicidal existed despite increases in coping skills and decreases in the perception of the magnitude of emotions and stressors:

> They say time heals and ya it does but it doesn't erase everything, you know. There's still a painful hole there that you can't fill. I think it will be there for the rest of my days, just like everybody else.

In many cases, they spoke of their acceptance of the continuity of that pain, "There will always be new tensions but I feel much more comfortable with them." These excerpts show the impact of increased coping skills in managing emotions and also a realistic perspective of potential future self-harm.

Despite being nonsuicidal, a shadow of suicide that followed them around, "I've always thought about the idea...The thought is always there." This residual suicidality was further described by participants as a haunting shadow of the stigma of suicide and associated feelings of shame and guilt. It was also described as the awareness of a chronic possibility in the back of one's mind, held "just in case things get difficult", such as in the Paradox of Suicide. This allowed participants to preserve a sense of control if the need for relief from

Compressing emotions arose again.

During follow-up interviews, some participants were asked about the presence of suicidal feelings after acute emotional episodes or attempts. Not all participants experienced this residual suicidality:

> I'm still working on stuff. It's coming out slowly now because I have more control over the flow of emotions. The thing that's different now is I know the pain is going to end. I still cycle through those stages but it doesn't get to the point where I become suicidal. I cycle much quicker now. This cycle went faster once I figured out why I was suicidal. It has all been progressive – one step leading to another. I don't think it could have happened any other way. I needed to go through those stages.

Another participant adamantly shared that she is no longer suicidal and that her suicidal experiences were enclosed in a definite time period, "It's not an option anymore."

Despair

The processes involved in participants' sense of extreme hopelessness, "beyond hopelessness" is conceptualized in the Despair category. Participants spanned the hope continuum throughout their experiences with periods of hopelessness, despair, and regaining hope. Excerpts describing hopelessness include the following, "I just don't know if I'm willing to pay the price [of life] anymore." "I'm like a canoe caught in the current and just running with the water. Other people my age seem to have it together. I'm tired of fighting. I'm tired." Despair enters the picture as participants "get to a point, totally screwed up, lost total track of time, beyond hopeless, hopelessly lost, all negative thoughts, lack of understanding." In this excerpt, Despair was acknowledged in his awareness of the lack of understanding.

One participant described this category in the following excerpt.

> I felt that the notion that there is goodness in the world, that people are

> decent and that I could have a happy life were happy myths from my childhood... like the existence of Santa Claus...I did not think I could handle the pain of living in the world as I now understood it.

This excerpt represents a global perception, although many participants described the feeling of Despair in more microscopic terms, "To feel unnoticed and never find bliss, to feel unloved and forever wander. Insignificant, unnoticed, unimportant." Hope is regained according to reports of thoughts about the future, "I am looking forward to health if I can fight long enough."

> Written in a bathroom wall I see a sign that says 'Life sucks, I hate it here. I wish I were dead', and I start to think, why is it written there? Who would write that life sucks? Who would say they care? Life is what you make of it... And then I realize that it was me who could have written that and now it is someone else... Something small will not bother me. I will become free. I will survive any fall that suddenly comes upon me. I won't let anyone hurt me. My feelings will show how much I dislike hate in this world. I'll make sure I'm happy.

Compressing. Feelings of hopelessness were abundant in the Compressing stage, "I was hoping but things weren't getting any better. It's like seeing something at a distance. It's a pinhole and then it expands into a black hole." "Youth is a time when you can try anything and it doesn't matter if you ever succeed because you have all the time in the world for it. I feel as if time has just run out for me." "I guess dying is an easy way out but must I fight this losing battle forever?" "I feel as if I have no life. Nothing keeping me going. Nothing is supporting. No single reason why I need to live. Nothing. Nothing. Nothing." "I've been depressed for a long time and I'm tired of being this way."

Blocking. Generally, the transition from Compressing to Blocking emotions reflected the point at which hopelessness and despair set in. Few comments regarding the Blocking stage of awareness with Despair were evident in the diaries. My assumption is that the energy to write about this stage was limited and some participants concurred with this hypothesis. Perhaps the act of writing during this stage exacerbated the feelings, thereby contradicting the blocking function as a protective factor. Retrospective accounts were more abundant. "I couldn't see any hope if it was staring me right in the face. Not then."

> And you think well maybe I should hang on and see what happens tomorrow. And tomorrow doesn't get any better. All you're going to see is the negative and you're constantly spiralling downward.

Allowing. The transition from blocking feelings of Despair to Allowing emotions was difficult for participants to conceptualize. It seems that there was a reemergence of hope described as "lifting of despair" but the mechanisms working behind that transition are complex. There were many comments about regaining hope at the initial end of the awareness continuum. This transition out of Blocking seemed particularly difficult and time-consuming, "It just blew me away that there was other people thinking the same things I was." "I want to stop wanting to die and find a way to live. I don't even know how to begin right now." "I wish I could find peace from within. I don't understand why God spared my life. I wish he could show me the way from here." Towards the integrative end of the awareness continuum, the following excerpt further illustrates Allowing:

> I actually remember thinking, I have to walk across the room and I did it! And it was like the connection of the two together. The action, the thinking, and being able to do the actions. I could focus more and that gave me hope. And then I slept for three hours. Deep sleep. The shaking stopped. THEN, the depression really came in.

This excerpt not only describes an integrative account of the transition from despair to hope, but it clearly illustrates how fast the cycle can repeat itself.

Isolation

The processes involved in participants' feelings about connections with others and with self are conceptualized in the Isolation category, "The sense of never being listened to... Everyone was being too busy to listen to my pain." This category encompasses the feelings of detachment from others and how that detachment transfers to connection with others as initial awareness develops into integrative awareness. It also encompasses the feeling of disconnection as a function of self-preservation, especially when connection with others exacerbated emotional pain.

Compressing. At the Compressing stage, feelings of Isolation became too intense for what the participants felt capable of handling.

> I had this sense of never being listened to. Everyone was being too busy to hear what I had to say, from a child. It seemed that when I put out a call for help there was never anyone there to answer it. Everybody talked too much in my family, and had certain things they would talk about. I had nothing important to say.

Even when people were around, there was never the feeling of being listened to.

> They had never respected my boundaries and I was never allowed emotional space... so I didn't have a right to have any feelings at all and so the emotions were all building up... I don't know if it was the isolation or the rhythm of always turning feet (riding bike) but I started to think cyclically, my thoughts were going round and round and I just couldn't find a solution... And I started to feel worse about my thoughts and so there's kind of a heaviness that descended.

In retrospect, the participant's awareness of how Isolation was operating in relation to Powerlessness is apparent in this except:

> That's when I started to get ill because I was isolated all the time and I started to think about the life situation. I was aware of my situation and I didn't have any power. It felt like I was the only person on a ship that was sinking that realized it was sinking."

Blocking. Participants were particularly animate about the secrecy involved in being suicidal. In the beginning stages of feeling suicidal, there were many reasons for the secrecy. Some included the intention to prevent hospitalization and overreaction, prevent hurting loved ones, prevent stigma of the suicide taboo, preventing conflict, and protect oneself from others knowing about the suicidal feelings, "I will never again tell him if I feel suicidal and if I go home and take those pills, it's my business because its my life, such as it is." "Don't show pain. If you ignore it long enough it will either get better or go away completely. It's wrong to feel suicidal so don't allow your mind to even know it's there."

> I didn't feel comfortable approaching them on my own. So I imagine now they thought I'd become snobbish or standoffish but in actual fact I just felt so horrible I didn't deserve friends, or any kind of social interaction or fun.

One participant said that she destroyed some diary entries so that no one would read about her suicidal feelings, for fear of being judged or labelled or having to explain something to someone else that she, herself, did not quite understand. At the Integrative level,

> From my diary I was very aware that I did not want to be a suicide attempt... I did not want to live with the stigma or be emotionally abused with the belief that it is jut a form of manipulation or call for help. If I was going to do it, then I was not going to be resuscitated.

Also in retrospect:

> During the first time it was like I had this secret that I wasn't going to

> share with anybody. I didn't want anybody else to know. I knew they would all feel bad once they found out the hard way. I was very private about it.

This secrecy evolved into a type of isolation that was either welcomed (e.g., "I was living in this bubble and nobody around me understood. It was a release, a comfort." "The break from the people with whom I had connections also gave me much needed space") or resented by the participants (e.g., "When I am yelling for something, listen! I'm tired of screaming listen. If I tell you I'm hurting believe me, don't just hear me, do something about it"). In many cases the secrecy became an investment in privacy, "Nobody gets it. Everybody was always trying to get in and be a part of my life and I just didn't want anybody, and nobody understood, including me." "My biggest fear is no longer of being isolated so much as always by myself." "I feel like I'm in a full room and no one understands or even sees me." Sometimes this privacy functioned to protect other people:

> I feel that some of the group members need protecting. They're kind of fragile and there's no point in making it worse and giving them more things to worry about by telling them my suicidal thoughts.

Participants also spoke of deferring to the therapist, "I told her what she wanted to hear and that gave me room to delve into my suicidal thoughts." This deference was complex, especially considering the ambivalence involved. Some participants wanted to keep the secret *and* receive help. In other ways, the deference allowed the suicidal person to minimize stress by eliminating the additional stress of having to deal with someone else *knowing* that he or she was suicidal.

Allowing. Connection evolved out of a breaking of the secret. In many cases this connection was not welcomed because it threatened having control over potential relief, at least initially. Here, Isolation and Powerlessness interact in the sense that holding the secrecy of suicide established control over the psychotherapy, the relief, or other situation. In this sense, feelings of being isolated from others functions as the perceived need to protect one from the consequences of sharing suicidal feelings. As control is reestablished, feelings of isolation may increase as a result.

> My parents didn't recognize it. My sister recognized it and she told. She didn't just recognize it; she acknowledged it. I'm not exactly sure what she noticed but she saw me carving and that's when they [parents] started at me. I didn't like it at first, more loss of control. But finally we found a suicidologist, a really good one. That one meeting with him was the most validating experience - recovery hello!

The validation that this participant spoke of contrasted with the fear of others finding out and overreacting or not understanding enough to be helpful. Eventually the benefits of breaking the silence were acknowledged, "I started to get the attention and they stopped feeding off of me so I was able to think about my own needs and I was able to have my own space." "I remember telling my mom that I wanted to kill myself and she just burst into tears because she never knew. But that was after we started talking." Sometimes the Isolation in relating to the therapist and how the therapist was allowed in the loop was openly acknowledged:

> We sort of ganged up on Dr. X because he hasn't gone through it and has no idea what were going through. We get him to listen and we sometimes brag about it because it's easier to talk about it that way.

Connection was not always regained in human relationships. One participant related her experience to a TV program with Vietnam veterans and Holocaust survivors and found that connection helpful, "It made me feel less isolated." In one other case the connection fueled the suicidal thoughts because the participant was connecting with another suicidal person. "We were both in our own little bubble at the same time. But that was our connection. She introduced me to carving." Connection was also evident in participants' relationship with themselves, "Turned a corner and saved someone but didn't figure out who, until I looked in the mirror."

A single excerpt may represent all emotion processes identified in this study. For example, the following excerpt was recorded during a follow-up interview:

> I think the permission and then the Isolation gave me the relief and the peace to think... perhaps a bit more clearly... and certainly in increments... about what the horror really is... and where it comes from... and the peace and relief fed my hope... But when I was suicidal I couldn't see it.

Fear

Fear was a consistent emotion expressed by participants in their diaries and in the interviews. Fear spread over the entire process, surfacing as fear of emotions, fear of life, fear of death, fear of recovery, fear of relapse, fear of hospitalization, and fear of self, "I am so afraid of me." In fact, one participant shared that "the fear is the hardest to deal with." Fear frequently coincided with the other suicidal emotions. Fear, Powerlessness, and Isolation frequently coincided. For example, the fear of hospitalization or stigma of suicide led to keeping suicidal feelings from other people. This fear comprised of anxiety about whether their suicidal thoughts and feelings would be taken too seriously or not seriously enough. "I didn't tell her (counsellor) about the cutting because I didn't want to be admitted anywhere or labelled a psycho or something..." This tendency to hide feelings encompassed suicidal feelings and feelings in general.

> But there was a lot of things that I didn't tell her because she was a stranger, she was a doctor, and she was reporting back to my parents and I didn't want them to know those things. I told her what she wanted to hear for the most part but I kept a lot of private things private.

Compressing. Joint experiences of Fear and Powerlessness were evident in the Compressing stage. The fear of being consumed by suicidal feelings was overwhelming and threatened participants' sense of control. The fear of loss of emotional control with respect to acting on suicidal plans was evident. "I didn't know if I would snap out of it in time." "I'm afraid I will take my life in the next few weeks and I feel so impulsive right now. I don't think I'll take the time to talk to anyone."

> In therapy today I realized I want to go home. I want to know how I feel inside when I go back. When I think about it I wouldn't think twice to OD again. The feeling really frightens me.

Fear of specific compressing factors was evident in the Compressing stage.

> Dad – incongruent word – it seems to bring only fear for first reaction, second – run, stay away, third – hurt, four – not good. It's not a safe place to be and I don't like it there. I hate getting too close. I start to shake and sweat and I want to run!

Blocking. At the Blocking stage, compressing emotions dissolved into the background. They were replaced by fears of the consequences of suicide and death, "I want to die and I'm too chicken", and also the fear of others finding out and overreacting.

> Like I was scared of dying. When I actually had the safety off and the barrel against my temple or in my mouth or something – I'd feel really scared. Like of what's going to happen next. But the pain of living was so horrible so it's like there was this very thin place I was existing - like in biology the two pieces of glass so you can look at something under a microscope. Very crowded place.
>
> Ya, you want the pain to be over so badly but you have the fear of dying because you really are afraid to hurt yourself. It doesn't matter how depressed you are, everybody's afraid to hurt themselves. It's so much

> easier to wish for someone else to kill you and I wished it – I wished I could hire someone to kill me. Because killing yourself simply goes against everything that's in our brains – we want to live. And I think people who go through with it suffer to a degree that I can't understand... I hated living. It was just painful. Every second that ticked by was excruciating. It was just torture to be alive. It's a big mystery too. It's a very scary thing when you're in that preface to just say, 'what will happen to me after I pull the trigger'.

The following excerpt further illustrates participants' experiences of the process of being suicidal and feeling the need to block emotions but working through those emotions instead, illustrating the movement from blocking to allowing emotions. "But at the time I didn't know I was recovering. I was trying to make sense of my world but it was stressful so it didn't seem like recovering."

Allowing. Once emotions were allowed back into awareness, similar compressing fears emerged about their readiness to be able to regulate those emotions. This fear was of losing control and feeling powerlessness to stop emotions, "That was one thing I was really afraid of - that it [hysterical crying] couldn't stop once I tapped into it. It might not go away."

The fear of recovery was as immobilizing as the fear of death. "I am so afraid and unsure of my future." Sometimes it transitioned into a mobilizing fear. "As much as I am afraid, I know I must do this [psychotherapy] if I'm going to get well for myself and my family." "In looking back I realize that fear of what I'm not too clear of, made me want to take control that I fought so hard for."

> In some ways things are getting better but they always do. What will happen if I go home again? Why I can get it all together in the hospital and then I can't handle it out there in the world?

An interesting finding about fear of recovery is the fear of failure,

> I was never allowed to make any mistakes. I never felt that if I made a

> mistake there would be someone there to pick me up. I suppose if you make a mistake that was it. That fear of not knowing how to deal with mistakes because I never made any.

The fear of relapse was evident along the awareness continuum but it was more prevalent in Integrative Awareness. In some cases, one's fear of life was evident in the beginning phases of the Allowing process and in fact may have precipitated a movement to the Compressing stage. "In some ways things are getting better but they always do. What will happen if I go home again? What if I can't handle it out there?" "The fear is the hardest to deal with. The never knowing if what you say or do is the right thing. Always eggshells". The fear of relapse signifies the magnitude of the pain in the emotional process - for participants the automatic knowing that they did not want to go back there no matter how long it had been since they had strong suicidal feelings.

> Slept for most of the morning which scared me because I thought I was slipping back into my old ways but after writing this I can see I really needed the sleep."

It seemed to create hypersensitivity to their symptoms.

Summary

The emotional process of being suicidal is complex. However, one main theme ties all the categories together throughout the entire process. This core category of Developing Emotional Awareness evolved and developed along a continuum from Initial Emotional Awareness and evolving towards Integrative Emotional Awareness. Three stages of Developing Emotional Awareness were evident along this continuum, Compressing, Blocking, and Allowing emotions. As emotions reached an individual emotional threshold, the participants seemed to find a way to block the feelings. Once the threshold changes, for example, with new coping skills or support, emotions are allowed back into awareness. If this process happened too soon, participants would go back to the Compressing stage. As such, the process of developing awareness of one's emotional process transformed into coping skills that reduced lethality levels. The feeling of being suicidal that comes in and out of awareness consists of some combination of these emotions, Powerlessness, Despair, Isolation, and Fear. A discussion of these findings is presented in the next chapter.

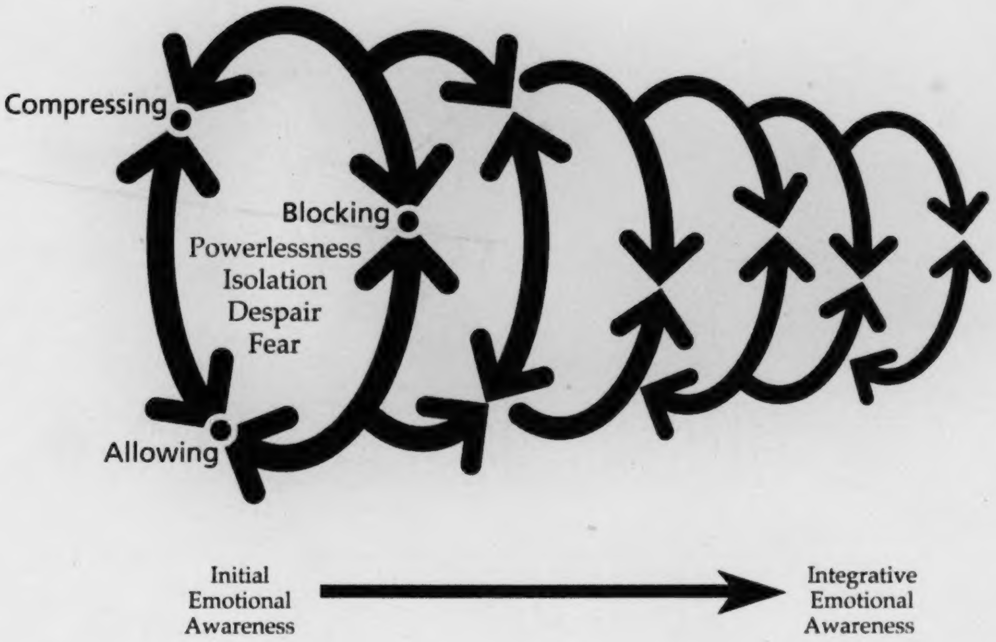

Figure 1. The emotional process of being suicidal. Suicidal emotional processes go through all stages of awareness on a continuum of DEVELOPING EMOTIONAL AWARENESS, which fosters increased coping abilities.

Chapter Five

Discussion

The purpose of this study has been to explore clients' perceptions of their emotional process when suicidal, in order to better understand that process. This purpose has been served in the finding of the dynamics of the core category, Developing Emotional Awareness. Specifically, findings contribute the clients' perspective to existing evidence of the importance of emotions in therapeutic change (Orlinsky & Howard, 1978; Paulson et al., 1999; Paivio & Greenberg, 2001; Rogers, 1959), and specifically in overcoming suicidal feelings (Edwards & Holden, 2003; Paulson & Worth, 2002). This chapter provides a discussion of the findings in the context of existing research and theory in suicidology and psychotherapy.

Research Findings

The analysis generated by this study suggests that suicidal persons gain life-protecting coping strategies via growing awareness of their emotional process. The core category, Developing Emotional Awareness, reflects the dynamic processes of Compressing, Blocking, and Allowing emotional experiences, with participants generating increasing control over those dynamics as they move from their initial state of emotional awareness towards more integrative experiences. In the analyses, these three stages, including feeling overwhelmed by emotions, suppressing emotions, and allowing emotions to reemerge, were followed in four main emotions common to all participants, Powerlessness, Isolation, Despair, and Fear.

No located study investigated the emotional process of being suicidal, until now. As such, the results of this study are discussed in the context of existing theory and research on emotional awareness (Linehan, 1993; Perls et al., 1951), the emotional process (Greenberg, 2003), the emotional process in the context of psychotherapy (Bolger, 1999; Greenberg, 2002, 2004; Stuart, 2002), and emotions in suicidology (Hoover & Paulson, 1999; Leenaars, 1996; Paulson & Worth, 2002; Shneidman, 1987).

This research complements the existing state of emotion and suicide research in several ways. First, it examines the emotional process from a broader lens than the therapeutic experience and it examines the emotional process from a broader perspective than individual emotion events and the processing thereof. The focus on the suicide process further delineates this study from previous work. The results are consistent with previous evidence for the influence of regulated processing of emotions on therapeutic change (Greenberg & Bolger, 2001).

The processes generated from in-depth interview and diary entries in this study do not offer concrete solutions to the problem of suicidality. More accurately, this study offers important insight into the emotional experience of being suicidal, which is essential in working with suicidal persons and generating theory. This study identified the major emotions experienced by suicidal persons, Powerlessness, Despair, Isolation, and Fear, as well as an outline of a process for understanding those emotions. Suicidal persons go through these emotions via awareness through Compressing, Blocking, and Allowing stages, which evolves into coping skills that inevitably reduce the risk of completed suicide.

Hoover and Paulson's (1999) exploration of helpful aspects of psychotherapy with suicidal persons offers the Self lens. Their participants described the suicidal process from the perspective of evolving self, which concerns the construction of new perspectives throughout the process. Bolger's (1999) findings also found the Self lens in the psychotherapy process of adult children of alcoholics. This study is unique, then, in the sense that it attends to the awareness lens of being suicidal, thereby complementing the Self lens.

Developing Emotional Awareness. In this study, the core category of Developing Emotional Awareness represents a growing level of insight of one's emotional process. This increasing insight may be understood on a continuum beginning with Initial Emotional Awareness, or whatever level of emotional awareness is evident when one begins to feel suicidal. This initial awareness develops into relatively more integrative awareness where participants became more skilled at noticing and understanding their emotional process. This Integrative Emotional Awareness represents the person's developing insight and perspective into suicidal feelings. Developing Emotional Awareness, then, represents the dynamic evolvement of initial stages of emotional awareness to integrative stages of emotional awareness. Generally, this awareness dynamic represents the development of conscious acknowledgement of emotions and, eventually, the manipulation of those emotions.

The awareness component of emotions is a well-accepted phenomenon in the counselling literature. In fact, this study adds credibility to a number of theoretical approaches to emotion that involve an awareness component (e.g., Greenberg, 2002, 2004; Linehan, 1993; Perls et al., 1951). Perls and his colleagues describe a continuum of emotional experience which has to do with the extent to which experiencing of the gestalt has emerged from ground to figure, influencing awareness of what is of matter to the self so that action may be directed towards those matters. This is consistent with the continuum in this study. In both Perls' et al. writings and this study, it is not the intensity of emotion that is followed by awareness. Rather, awareness is seen from a broader perspective in that it is the person's awareness of his or her ongoing experience, whether that experience is intense or suppressed. Both also deny the notion of absence of feeling. So things such as frigidity, boredom, numbness (Perls et al.), and the blocking of emotional intensity are, in fact, strong emotions that have a purpose. Numbness, for example, may be understood in the same way that Blocking is presented in this study as a powerful stage of emotion that is "so strong it is soon excluded from awareness" (Perls et al., p. 96). The problem may be that societal pressures advocate for the suppression of emotion. Rather, emotional experiences may, in fact, be helpful by permitting "the way nature designed organisms to function" (Perls et al., p. 97).

Perls' et al. (1951) description of "integrating awareness" is also consistent with the findings of this study. As awareness becomes more integrated, assumptions about the threshold of emotional tolerance are challenged and feelings of agency and control emerge. Gradually, individuals recognize that deliberate suppression of emotions is unnecessary since one does not fall to pieces. As energies realign, persons "begin to feel more alive and more spontaneously expressive" (Perls et al., p. 111). Through a process of sharpening one's awareness of their emotional experiences and putting them into words, one begins to feel more alive and genuinely expressive and one begins to organize his/her experiences into more meaningful wholes, "genuine self-integration" (Perls et al., p. 112).

Other theoretical and practical thought about awareness of emotion include Linehnan's (1993) emphasis on mindfulness in dialectical behaviour therapy. Mindfulness is a meditation technique emphasizing observing and noticing one's self in context, participating with awareness, and describing those observations in nonjudgmental terms. The idea is to focus on the facts of one's experiences without interrupting those experiences in order to gain control over impulsive reactions to one's unbearable emotions. Similar ideas are evident in the awareness experiments proposed by Perls and his colleagues (Perls et al., 1951). These ideas are consistent with the growing ability of participants to be able to step back and notice their experiences in order to develop more control over those experiences.

Therapies such as EFT emphasize the need to "build awareness of emotion as a first step to better adaptation" (Greenberg & Paivio, 1997, p. 26). The core category of Developing Emotional Awareness reflects Greenberg's (2004) concept of awareness in emotion processing. In both Greenberg's ideas and this study, participants became more efficient at labelling their emotions and using them as informing agents, here, in resolving suicidal feelings. These findings are consistent with Greenberg's (1993) theory that distressful problems are resolved by attending to emotional experiences and integrating reasoning with that experience. As such, the findings of this study add credibility to EFT, which builds heavily on the development of awareness in managing and learning from emotions, and in fact tags awareness as the first and most general goal (Greenberg, 2004). Awareness helps to make meaning out of ongoing experience. Then, meaning construction influences what one attends to in the future (Greenberg, 2004).

The concept of emotional awareness is closely tied to emotional intelligence.

> Being aware helps each of us handle feelings so that they do not overwhelm, and helps us soothe ourselves and manage our anxiety, anger, and sadness. Emotional intelligence also involves being able to control impulses and to be able to motivate us (Greenberg & Paivio, 1997, p. 25).

The role of awareness as an adjunct to emotional intelligence in the emotional process of being suicidal is implied. Learning potential, then, plays a significant role in coping more effectively (Salovey, Bedell, Detweiler, & Mayer, 1999). Tugade and Fredrickson (2004) argue that it is emotional intelligence that allows psychologically resilient people to be able to use this intuition and knowledge of emotions, especially positive emotions, to better cope during periods of stress. The need for emotional regulation in the context of suicidality follows from Iancu's et al. (1999) finding that suicidal individuals experience emotions at a greater intensity than nonsuicidal individuals. The reason for this finding is not known but it may be speculated that some suicidal persons, at least during the suicidal phase possess limited emotion regulation skills or other problem-solving skills.

These results bear some connection with Stuart's (2002) study on client's perceptions of emotional experiences in counselling although the differences in the scope and purpose of each study are remarkable. Stuart's research focused on the emotional experiences in counselling whereas this study is broader than psychotherapy in scope but it is isolated to the suicidal process. Both studies identified emotional awareness as the vehicle for change. Stuart's stage of Increased Emotional Awareness parallels the overall awareness theme of this study, Developing Emotional Awareness. The difference is that psychotherapy clients in Stuart's study made a conscious effort to examine and inspect their emotional experience, by seeking psychotherapy. Although this may have been the case for some of the participants in this study, psychotherapy was also conducted in the context of crisis and many times involvement in psychotherapy evolved out of the person's coming into contact with emergency rooms. Stuart's *Negative Influence of Emotions* cluster resembles the Integrative Awareness category in this study. Statements in this cluster reflect an awareness of how avoiding emotions was impacting on their lives prior to dealing with them in a therapeutic context. However, it was not always apparent how much insight was dependent on a therapeutic context in this study.

The awareness component is subtle in the suicide literature. It may be understood, when at high risk, as too much awareness and attention onto specific experiences and, at least at first, having minimal ability to tolerate that awareness. In this respect, a different quality of awareness is lacking, that is, awareness of how one is experiencing his or her emotions or rather a step back in quality of awareness. Psychache (Shneidman, 1993) is intense and overwhelming, so much so that it is blocked, stopped, or suppressed, either by switching awareness, attempting suicide, riding it out, or by some other means. In this respect, the blocking has an adjustive (Shneidman) value and allowing and expressing intense emotions at this stage could have lethal implications. This lethal implication of what one does with emotions indicates the difference between the emotion literature and the suicide literature, although the emotion literature acknowledges that emotions are adaptive or maladaptive. For the most part, it is contraindicated to allow and express suicidal emotions without having the necessary coping skills.

The awareness component of the emotional process of being suicidal is not directly apparent in Leenaars' (1996) psychological view on suicide. However, there is notable applicability of Leenaars' focus on the person's ambivalence to the awareness continuum of this study. He hypothesized that the person may be conscious of only a fragment of his/her suicidal mind (Freud, 1917/1974) and this study provides evidence that there is a growing awareness of one's suicidal emotions. So then, does this mean that there are unconscious forces in matters of suicide as Leenaars suggests? More importantly, in the interpretation of these findings, do conscious/unconscious processes parallel awareness processes? The answer is beyond the scope of this research and it is probably largely dependent upon theoretical beliefs. Along the same lines we must ask, is it constriction of awareness as suggested by these findings, or is it cognitive constriction, as suggested by Leenaars (1996) and Shneidman (1985) that best describes the suicidal period?

The main difference with Shneidman's psychological model of suicide (1987) and Leenaars' multidimensional model of suicide (1996) and this study is that the former two are based on years of clinical experience and research on completed suicides whereas this study is based on attempted suicide. An important ingredient of this study is that it bridges the experiences of persons who attempt suicide to knowledge about completed suicides. Specifically, the notion of threshold (Shneidman, 1987) of perceived stress is a commonality between the two types of suicide. Many questions remain unanswered. We know that previous suicide attempts correlate with completed suicides (Bland et al., 1998). But what is it that determines whether a suicide attempt is meant to be lethal? Certainly, many people in this study used lethal means (e.g., hanging) and even usual nonlethal means (e.g., overdose) may result in death depending on the availability to medical care.

Generally, the awareness category in this study differs from previous attention to awareness in the suicide and psychotherapy literature. For example, Hoover and Paulson (1999) discuss *Awareness of Suicide* in the context of knowing if one is suicidal, noting that many did not label their behaviour and impulses as suicidal. Their specific awareness focus is different than the focus on the emotional process of being suicidal in this study, although participants' awareness of being suicidal and having suicidal feelings was a component that emerged in this study. As this awareness increased, participants gained coping skills that helped them to work through suicidal feelings.

These results relate to another, theoretically informed organization of client experience. Rennie's (1992) concept of *Clients' Reflexivity* is described as a quality of self-awareness and self-control. Rennie's research is formed on the basis of client analysis of a tape-replay hour of psychotherapy, shortly following the session, using grounded theory methods. This core category, Clients' Reflexivity, encompasses consciousness, self-control over the process of psychotherapy (e.g., material offered to the therapist, metacognition, reflection, and reason). Rennie further explains reflexivity by identifying the concept of nonreflexivity as "the state of acting (including thinking) without awareness of the action" (p. 225). It may be compared with the core category of Developing Emotional Awareness in this study in the same sense that a suicidal person is constantly determining needs and assessing his/her environment and his/her interaction with the environment according to how those needs (e.g., Blocking, Allowing emotions) can be met, as suggested by van Heeringen (2001).

Stages of Awareness. Participants repeatedly went through three dynamic stages of awareness, Compressing, Blocking, and Allowing emotions along the continuum of Developing Emotional Awareness. These three stages were evident for each of the suicidal emotions. Participants went through these stages slowly at first, then faster as they gained a sense of agency over the process.

The Compressing stage consists of an overall state of feeling overwhelmed by emotions that threaten to exceed the person's available coping repertoire. This stage represents underregulation of emotions. The Compressing stage relates to concepts found by previous researchers (Everall, 2000) who have termed it emotional pain (Bolger, 1999) in the psychotherapy literature, and unbearable psychological pain (Leenaars, 1996), psychache (Shneidman, 1993), or mental pain (Orbach et al., 2003) in the suicide literature. It is the intrapsychic dimension of Leenaars' (1996) theory, the pain of feeling pain or metapain. The suicidal state of mind represents perturbation, which describes how upset (Shneidman, 1980) or overwhelmed the individual is at the time.

Shneidman's (1996) psychache or psychological pain is the conglomeration of multiple maladaptive emotions. This pain has parallels with the Compressing stage in this study. The main difference is that this study emphasizes the overwhelming nature of those emotions and their threat to one's sense of agency, potentially exceeding the individual's perceived threshold of tolerance for emotional intensity. This emotional translation of the vicissitudes of life (e.g., stressors, rejection, failures) directs the person toward suicide (Shneidman, 1993). The finding of individual thresholds adds credibility to Shneidman's idea of individual thresholds for enduring psychache. Given that Shneidman's ideas are empirically based in studies on completed suicides (e.g., Shneidman, 1971b), although his ideas are also based on clinical experience, the finding of this threshold in both Shneidman's (1993) and this study suggest a commonality between attempted and completed suicides. This threshold of tolerance for intensity also adds credibility to Iancu's et al. (1999) finding that suicidal persons experience emotions at a greater level of intensity compared with nonsuicidal persons.

The contextual development of this compressing emotional pain was described in Everall's (2000) study of the meaning of suicide attempts in young adults. Specifically, Everall found that emotional pain of the cumulative effect of repeated rejections and fear of rejection and failures translated into feelings of insecurity and diminished self worth. These feelings about interpersonal experiences became the impetus for establishing a self-protective mechanism of alienation to protect the self from future hurt. In effect, this transfer from interpersonal to intrapersonal aspects of being suicidal reflects Leenaars' (1996) multidimensional model of suicide where intrapsychic and interpersonal dimensions collide into a mess of unsatisfied attachment needs.

The Compressing stage resembles Orbach's et al. (2003) conceptualization of mental pain, as illustrated in their creation of the Orbach and Mikulincer Mental Pain (OMMP) Scale. Although they do not comment on the dynamics or process of the factors, those factors run parallel to concepts and processes inherent in this study. For example, lack of control, emptiness, and emotional flooding, may be paralleled with the awareness process of Compressing, Blocking, and Allowing emotions, respectively.

These results may also be compared with Bolger's (1999) grounded theory study on emotional pain of adult children of alcoholic clients. Briefly, Bolger's research provided a model of the stages in the process of working through emotional pain. Bolger's model centered on a core category, the Broken Self, characterized by four properties, including Woundedness, Disconnection, Loss of Self, and Awareness of Self. The Broken Self was described in the context of a concealing self, the covered Self, and an integrated self, the Transformed Self. In Bolger's model, the Woundedness stage is comparable to the Compressing stage. The Compressing stage adds the notion of individual threshold of emotions to the Context in Hoover & Paulson's (1999) study of psychotherapy experiences of suicidal persons. The sense of alarm, also highlighted in Bolger's study parallels the compression stage in this study. In fact, it may help to describe the transition to blocking emotional pain. Blocking in this sense reflects the fight or flight response to stress. Blocking may also be seen, then, to represent the flight from pain.

Stuart's (2002) *Breakdown of Coping Strategies* stage parallels with the Compressing stage with suicidal persons in this study. However, coping strategies were preexisting but not available to deal with the emotional distress in the psychotherapy clients in Stuart's study. Whether those coping skills were preexisting in this study was not examined.

Participants generally said that suicide was not a need for death, rather, it was a need for relief from life. Death was generally a side effect. In Shneidman's (1993) terms, the psychache needs to be mollified. Relief from compressing emotions was sought via a suicide attempt, blocking, or coping. The Blocking stage of Developing Emotional Awareness represents a threshold whereby emotions have reached the persons perceived capacity to cope effectively. Emotional pain mobilizes self-protective action, such as covering or avoidance, thereby fostering an overregulated state (Greenberg & Bolger, 2001), for the purpose of protecting one's self from the threat of emotions spilling over an invisible threshold. This self-protective action resembles the blocking function in this study. It also resembles the covering response that functions to hide the brokenness, disallow the emerging feelings, and reject or disown new insights about the self (Bolger, 1999).

The Blocking stage has, then, adaptive and maladaptive functions. In the former, the blocking mechanism stops the flow of emotions until coping skills are established, and this serves a life preserving function. Korman and Greenberg (1996) acknowledge the adaptive function of avoiding or blocking painful emotional material and the need to implement more adaptive coping mechanisms. This overregulation of emotions is indicative of the need for distress tolerance abilities (Linehan, 1993) in order to work through emotions.

The blocking mechanism may be further understood in the context of Anderson and Green's (2001) experiment on subjects' control over suppression of memories. Specifically, their finding that consistent attempts to prevent awareness of non-traumatic events may also apply to emotional experiences while suicidal. The control in this study involves emotions instead of memories. In Freudian terms, both emotions and memories are associated with avoidance or resistance. We know from the work of Anderson and Green that people have some executive control over suppressing unwanted memories but we do not know if those same neurobiological mechanisms are responsible for blocking painful emotions. However, the idea that both emotions and memories share neural pathways suggests a relationship in this respect. But, how is it that one can selectively block memories but that some participants who block painful emotions also block positive emotions? Further research is required to ascertain the role of this blocking mechanism, perhaps at the neurological level.

With respect to the maladaptive function, sometimes Blocking represents a suicide attempt. Participants' perception of the functionality of suicide is difficult to understand. That suicidal thoughts are adaptive to the suicidal person is not exactly an idea that is encouraged in a psychotherapy session. Rather, it is important to acknowledge the magnitude of what clients are experiencing and the notion that suicide *seems* adaptive in the context of such intense emotions. For example, it is important to note that sometimes blocking one's self off from abusive family members is adaptive. It is also adaptive when a person is reaching their emotional threshold and needs to control the amount of emotions flowing inward. Suicide is seen by the suicidal person as a functional response to ending unbearable pain (Leenaars, 1996). Logically it is not adaptive but it seems to be the only available option to remedy the pain, from the perspective of the suicidal person. This cognitive constriction (Leenaars, 1996; Shneidman, 1985) is one of the variables differentiating suicidal ideation, suicidal attempt, and completed suicide. Cognitive constriction increases risk for suicide for a person who is highly lethal. It is at this point that the suicidal person sees suicide as the most adaptive option (Leenaars, 1996; Shneidman, 1993). However, more options are recognized by persons using nonlethal means or other forms of blocking, such as distracting oneself from the pain.

Stuart's (2002) participants spoke of avoiding distressing material rather than blocking it all together. Interestingly, in Stuart's study, avoidance and distraction were considered a breakdown of coping strategies, suggesting perhaps that the emotional intensity level in nonsuicidal clients may not reach the intensity level of suicidal clients, therefore differentiating the need for a blocking mechanism in the form of a suicide attempt. The implication is in conceptualizing the reason for blocking. In suicidal persons, the blocking mechanism may function as an adaptive or maladaptive mechanism. As such, it may be harmful to suicidal persons to prematurely disable the blocking mechanism before coping skills are put in place.

The Blocking stage may be understood in the context of evolutionary matters of adaptation. The Blocking stage parallels Rothbaum's et al. (1982) idea that passivity saves energy and allows meaning change to take place. This stage further parallel Bolles and Fanselow's (1982) hypothesis that deep physical pain motivates immobility that helps recuperation. It seems logical that emotional pain also needs immobility in order to create strength to deal with it further.

The Allowing stage represents the point at which emotions are permitted back into awareness to be dealt with. This stage represents a balance between underregulating and overregulating emotions. It represents an increasing coping repertoire that allows a manageable amount of emotion at a time, an amount that is consistent with coping abilities. This Allowing stage permits emotions into awareness, fostering a more integrative organization of experience. However, allowing emotions back into awareness may prematurely bounce the person back to the Compressing stage. This Allowing stage is not apparent in the writings of neither Shneidman nor Leenaars, mainly because they studied completed suicide and the participants in this study survived their attempts.

The Allowing stage in this study resembles the process of working through emotional pain in Bolger's (1999) study. Simply put, emotions are allowed back into awareness to be dealt with. In Bolger's study, this stage encompassed accepting the loss of control, overcoming the fear that the emotional pain might destroy them, allowing fear and shame, letting go of behaviour that covered the pain, tolerating the tension of seeing their broken selves, and allowing questions to emerge.

Regarding the overall process, Stuart's (2002) concept mapping study of emotional experiences in psychotherapy, the emotional process begins with avoidance of emotions and moves to recognizing the negative influence of emotions, volatility or expressing emotions, understanding emotions, dealing with emotions, resolving emotions, integration and finally connecting to self. This process differs with this study in the sense that avoidance begins the process in a counselling client, whereby compressing or overwhelming emotions seem to start the cycling for a suicidal person. Although this finding may reflect the different time dimensions attended to in both studies, I suspect that a suicidal person goes through the process at more intense levels than an average client, although Stuart does not comment on the temporal speed of the process for psychotherapy.

The stages of the emotional process found in this analysis are slightly different from the stages of allowing and accepting painful experiences presented by Greenberg and Paivio (1998). As with Stuart's (2002) study, part of the difference has to do with where the descriptions of those processes begin. It is important to keep in mind that this study specifically looked at suicidal persons. In this study the process begins at the Compressing stage where emotions are experienced at overwhelming intensity levels. The second stage, Blocking, fits more closely to Greenberg and Paivio's stage of approaching or avoiding. Both have an Allowing stage and Greenberg and Paivio take it a few steps further by including accessing the reowning of painful experience by accepting that experiencing and reestablishing agency or control. This leads to a feeling of relief and self-affirmation, steps of which are alluded to in the Allowing stage in this study.

The stages of awareness have further important parallels with Greenberg and Paivio's (1998) ideas in the context of EFT (Greenberg, 2002). Although Greenberg does not specifically discuss suicidality in the context of EFT, his theory has important implications for facilitating an adaptive emotional process for suicidal clients. At the Compressing stage, the client is overwhelmed, indicating that emotion regulation, rather than emotional arousal is advisable and further expression of emotion is contraindicated. When emotions are avoided or blocked, emotional arousal is eventually facilitated (Greenberg), leading to the Allowing stage. Given the suicidal population, it is extremely important that the transition from Blocking to Allowing be facilitated with coping skills in order to continue the adaptive nature of the emotional process. Put bluntly; avoid lethal attempts to block by helping the client find nonlethal ways to block until the client is equipped to unblock those emotions adaptively. In a safe therapeutic relationship, coaching can facilitate this process, all the while fostering emotional intelligence (Greenberg). Overall, Greenberg warns that emotions should be assessed according to their adaptability. Suicide is not adaptive, although, it feels adaptive to the suicidal person, at the time. The bottom line is that this assessment of adaptability indicates whether emotional expression should be facilitated or blocked until additional coping resources are established.

Suicidal Emotions. Suicidal emotion processes consist of the emotions that bore the most commonality among participants. They include Powerlessness, Despair, Isolation, and Fear. Again, these emotions may occur in nonsuicidal individuals; however, their intensity may be more specific to suicidal individuals. Also, the finding that all four emotions were experienced consistently in these individuals helps to differentiate suicidal feelings from nonsuicidal feelings. They are discussed here within the context of participants' evolving awareness of their emotional process.

The Powerlessness category represents a feeling of loss of control over managing stressors and emotions. This category corroborates Everall's (2000) Self-Control category in her exploration of the meaning of suicide attempts to young adults. In Everall's study, control represented efforts to control life and were experienced as futile and this was realized in the sense of hopelessness about the future.

Feelings of powerlessness in this study are consistent with some of the intrapsychic and adjustment components in Leenaars' (1996) theory. Leenaars refers to a state of heightened perturbation in which the person feels boxed in and considers him/her too weak to handle personal difficulties, translating into a feeling of losing control.

The lack of perceived ability to exert control over one's environment is evident in the Blocking stage of emotional awareness. In fact, passive and withdrawn behaviour, and other types of inward behaviour, serve to reestablish temporary control (Rothbaum et al., 1982). Submissiveness to a leader, such as a therapist, may allow the client to benefit from that leader's power in a form of vicarious control (Rothbaum et al., 1982), thereby implicating the therapeutic relationship in fostering temporary control.

The Despair category represents this feeling of extreme hopelessness, which evolves into hope. Hopelessness and helplessness are the common emotions in suicide (Shneidman, 1987). They are the emotions of impotence (Leenaars, 1996). The use of the term Despair instead of hopelessness in this study is meant to highlight the unbearable nature of hopelessness, "beyond hopelessness". The transition from hopelessness to utter despair may be the turning point that differentiates a lethal suicide attempt. For example, some suicidal persons are able to regain hope prior to completing suicide. The question remains, *How is hope reestablished*?

The Isolation category represents the feeling of detachment from others. This category bears resemblance to a number of studies. It is consistent with much of Leenaars' (1996) thought on the contributions of one's inability to adjust and unhealthy interpersonal relations in being suicidal. With respect to the adjustment hypothesis, both Leenaars (1996) and Linehan (1993) agree that attachment problems with a lost or rejecting person contribute to egression. This feeling of being detached from others is related to past and present interpersonal situations, frustrated attachment needs, and fear of abandonment (Leenaars). This study has to do with the ongoing experience of being isolated from others, complementing Leenaars' theory and offering further understanding of the secrecy aspect of feeling suicidal.

The secrecy of suicidal thoughts and feelings was reported as withholding disclosures of suicidal thoughts and feelings from the therapist, as well as from family and friends. This secrecy represents an internal editing component, whether for reasons of stigma, potentially unwanted intervention, protection of the therapist, or lack of connection between client and therapist. This secrecy bears resemblance to Rennie's (1992) hypothesis that "what the client says in therapy does not necessarily reflect what he or she is thinking" (p. 229). Rennie's (1994) core category of Deference was found in an analysis of immediate tape-replay assisted interviews with fourteen psychotherapy clients. This deference was described as a silent submission to the therapist. This agreeableness was evident in this study in the Isolation category, whereby some participants told the therapist what they thought the therapist wanted or needed to hear. The reasoning behind this mask of secrecy parallels Rennie's properties of concern about the therapists approach, fear of criticizing the therapist, understanding the therapist's frame of reference, meeting the therapist's perceived expectations, accepting the therapist's limitations, threatening the therapist's self-esteem, and indebtedness to the therapist. In this study, the secrecy was related to protecting others from suicidality and protecting oneself from overreaction on the part of the therapist, such as suggesting hospitalization prematurely or without regard to collaboration if collaboration was possible.

The treatment repercussions of the stigma of suicide as a sign of weakness and the nature of suicide as a taboo subject, realized by Rogers and Soyka (2004), was expressed by participants in the Isolation category. The Isolation category functions as a hindering factor that can be further understood by looking at Paulson's et al. (in press) study of hindering psychotherapy experiences of suicidal youth. Briefly, Paulson and her colleagues uncovered two main negative experiences in psychotherapy, impediments to the development of a therapeutic relationship and hindering therapist interventions. Despite the differential age categories of these two studies, the hindering factors found with adolescents are evident in this adult suicidal population, namely the participants' sense that it is not safe to talk about suicidal thoughts and feelings.

This microscopic view of the role of Isolation in being suicidal compliments Everall's (2000) exploration of the development of feelings of isolation and alienation that lead to the state of being suicidal. Whereas Everall looked at the meaning of suicidal attempts for young adults, such as chronic alienation from others that leads to suicidal feelings, this study uncovered feelings of isolation about being suicidal that inevitably fuelled feelings of isolation from others. As such, isolation may be seen as a multilevel experience of alienation from others. Leenaars (1996) also looked at interpersonal relations more in depth than this study. He emphasized the influences of difficulty establishing and maintaining relationships and related feelings of rejection and fear of abandonment.

The Fear category represents the feeling of anxiety about emotions, life, death, recovery, and relapse. In fact, fear may be a demobilizing and mobilizing component of the entire process. In other words, fear of life may initiate one towards suicide and fear of suicide may initiate one towards other problem-solving capabilities.

Coping. The idea that knowledge of one's emotional processes impacts on coping cannot be disputed. In this study, coping and hence recovery, was gained through a process of evolving awareness of one's emotional processes. This may be understood from many perspectives, including evolving emotional intelligence and evolving emotional regulation, both of which are interrelated.

As participants became more experienced with their suicidal feelings, initial levels of awareness evolved into new perspectives and insights, which in itself was a relatively new coping strategy. In this respect, emotional awareness is a lens for the practitioner to understand the suicidal process and a vehicle for suicidal persons to gain better coping skills. This growing awareness emerged as a primary coping strategy consisting of mindfulness (Linehan, 1993), perspective-building, insight, and understanding that facilitated other types of coping, such as developing general problem-solving abilities, revising polarity thinking, and reserving the option of suicide as a way to manage short trials of life in pain, instead of considering the incomprehensible and overwhelming prospect of a life of endless pain. This particular coping strategy, although anxiety-provoking for the clinician, assists clients in proving that they are capable of managing and surviving life.

Overcoming suicide is attributed to increased coping and problem-solving skills in other research. Hoover and Paulson (1999) developed a theme of coping, consisting of multiple strategies of disconnection to cope with life, suggesting that their participants also utilized a blocking mechanism to filter a safe amount of emotion at a time. Both Shneidman (1985) and Leenaars (1996) emphasize the strong connection between suicide and deficient coping

The process from Initial to Integrative Emotional Awareness also reflects Edwards and Holden's (2003) distinction between emotion-oriented coping and more adaptive problem-solving forms of coping, and reflects the transition from the former to the latter. In this study, emotional coping represented an all or nothing mind frame, rather than knowing how to regulate the flow of emotions in tolerable quantities. More effective coping strategies emerged over time with increasing awareness of one's emotions and reactions to those emotions.

Application of Results

Glaser and Strauss (1967) emphasize four prerequisites to applying grounded theory. Keeping in mind that these results are intended to increase understanding as opposed to generate theory, these prerequisites apply to understanding the phenomenon rather than judging a theory. First, the results "must fit the substantive area in which [they] will be used" (Glaser & Strauss, 1967, p. 237). This chore was assumed by the nature of my adoptions of Glaser's emphasis on the traditional grounded theory methods, which do not force the data by generating endless concepts and categories beyond what is spoken about in the interviews and diaries. Readers may judge fitness from the descriptions of the method and how grounded insight on the emotional process of being suicidal fit the realities of previously suicidal persons.

Second, grounded insight must correspond closely to the realities of the area and it must be "understandable to the people working in the substantive area" (Glaser & Strauss, 1967, p. 239), such as mental health professionals working with suicidal persons. In this respect, the nature of the discussion is nested in psychological literature that is familiar to those working in the field. Concept and category naming was conducted with mental health professionals in mind, so that the results are understandable and meaningful. In this respect, care was taken to generate concept and category names that were sufficiently familiar, general, and meaningful to enable therapists to better comprehend those experiences. For example, concepts such as Awareness, Powerlessness, Despair, Fear, and Isolation are familiar to most working in this field, so that each professional may apply these concepts to their individual work, on the basis of their individual interpretations of the results. It is hoped that these concepts and category names and the general understanding that they purpose may inform and aid therapists in their treatment of suicidal clients.

Again, these findings suggest that clients' awareness plays a role in reducing lethality levels. Through the implication of awareness in reducing suicide levels, these results endorse ways of facilitating this awareness in healthy doses. Of course, forms of supportive therapy are implied in this regard. For some, specific distress tolerance skills may be the focus of learning. Throughout this process, care must be taken to support suicidal individuals by conducting psychotherapy sessions in a safe environment with opportunity for relief from Compressing. As such, the therapeutic relationship is implicated as a strong influencing variable, specifically with respect to collaborating and validating, and especially communicating to the client that it is safe to talk about suicide. Certainly, a therapist must be comfortable with his/her own beliefs and fears of working with suicidal clients. It is my hope that this research increases therapist empathy, and especially collaboration in decisions about treatment. This is important given the findings of feelings of isolation and powerlessness when feeling suicidal. In this respect, the findings lend credibility to the work of Michel et al. (2002), Jobes (2000), and Rogers (1957) on the benefits of empathy in the therapeutic relationship.

Third, the results "must be sufficiently general to be applicable to a multitude of diverse daily situations within the substantive area, not just a specific type of situation" (Glaser & Strauss, 1967, p. 237). This prerequisite deserves a second glance because the suicidal experience is atypical and typical in everyday life. For some it is the norm of their existence because of the chronic nature or constant reservation of the option to die. The results emphasize individual variability on this higher level category, but also on more specific aspects of the results. For example, if a therapist contemplates a transition in awareness using grounded insight generated herein, he or she may anticipate a range of consequences and variable speeds in individual processes, thereby correcting narrow assumptions of what might happen. The researcher has the responsibility to find the balance between generating concepts and categories that are both meaningful and abstract enough to account for generality and flexibility (Glaser & Strauss, 1967). This task is accomplished mainly through the use of a continuum structure of the main theme, Developing Emotional Awareness.

The last judgment of applicability follows automatically from the previous three aspects of applicability – application control. This prerequisite concerns enabling the user to predict and control consequences and to revise its use with flexibility in diverse situations (Glaser & Strauss, 1967). For example, it is emphasized that the Compressing stage is broad enough to take into account variable stressors and emotions. Results also emphasize the variability in individual thresholds. However, the Compressing stage does not offer specific information about how suicidal feelings emerge. Other information about a client may assist individual assessments.

Implications for Clinical Practice

Information gained from this research can lead to improving the treatment of suicidal individuals and to improving training of individuals who treat suicidal individuals. Implications for clinical practice stem from the notion that one cannot treat suicide; suicide cannot be reversed. Rather, therapeutic implications of this study have to do with the prevention of suicide and the treatment of suicidal thoughts and feelings. In this respect, there is much existing research and theory that is validated and supported by this study. For instance, empathy, as it is emphasized in both emotion (Greenberg, 2002, 2004) and suicide (Jobes, 2000; Michel et al., 2000; Orbach et al., 2002; Rogers, 1957) literature is indicated in the treatment of suicidal individuals.

These results imply that clients receive messages from society and their therapist, specifically about the moral and cultural understanding of psychotherapy and suicide. A client will notice therapist's verbal and nonverbal behaviour and he/she may make assumptions based on those observations. These assumptions may include what the client thinks about the therapist's views of suicide, how the therapist might react to suicidal disclosures or gestures, and whether the therapist may need to be protected from such disclosures. These assumptions are not likely to occur in an open manner. Nonetheless, the impact of these assumptions on potential disclosure of suicidal thoughts and feelings is obvious – suicidal thoughts and feelings remain untreated. Again, this ongoing interpretive activity is empirically documented by Rennie (1992, 2000a) who established the core category of Clients' Reflexivity as a sense of agency and self-awareness during the psychotherapy process. In this respect, Rennie identified the impact of verbal and nonverbal signs on clients' deference to the therapist and also to clients' control over what is disclosed.

This study corroborates existing ideas that psychotherapy is different with suicidal individuals. The emotional process of being suicidal is comparatively different than other emotional processes (e.g., Bolger, 1999; Stuart, 2002). Shneidman (1980) differentiates working with a highly suicidal person from other therapeutic encounters in that the goal is not of increasing comfort but of keeping the person alive. In doing so, transference of feelings is managed and countertransference feelings of affection and concern are legitimately indicated in such a potentially time-contained situation. When an individual is experiencing the Compressing stage, it is important to mollify the compressing experience, or in Shneidman's terms, decrease lethality by decreasing perturbation by making "that person's temporarily unbearable life just enough better so that he or she can stop to think and reconsider" (Shneidman, 1980, p. 419). The main goal is to "increase the individual's psychological sense of possible choices and sense of being emotionally supported" (Shneidman, p. 421).

Perhaps an obvious yet subtle finding in this study was that people can and will speak of being suicidal, if they feel safe to do so. Understandably, the willingness is inhibited when suicidal feelings are prominent and especially when it is difficult to put such experiences into words. However, some factors that contribute to this willingness may be influenced by the clinician, such as, the invitation to disclose, the collaborative philosophy of the clinician when considering hospitalization, and the indication that the clinician will not crumble or panic upon disclosure of suicidal feelings. Many of these factors are addressed at the outset of a counselling contract, although clients will inevitably pick up cues about what is acceptable to talk about and about how much of the counselling philosophy discussed in the beginning is actually put into practice.

No matter what portion of these results came from the therapeutic process, implications for providing those elements (e.g., awareness and allowing in a safe context) in the psychotherapy context are enormous. Reinventing the wheel, though, is less appealing than putting into practice existing theoretical ideas such as EFT (Greenberg, 2004) or DBT (Linehan, 1993), depending on the population being served in psychotherapy and according to the emotion assessment (Greenberg, 2004). Of course, these therapies may not be indicated when the person is at high risk for committing suicide. In those high risk situations, it is better to help keep the person out of danger (e.g., removing the means, hospitalization) and validating what the person is experiencing. Once the person is out of crisis, he or she is in a better position to learn strategies with less intense emotions so that he or she can apply same to more intense emotions as they arise. Specifically with respect to EFT, clients learn to approach, tolerate, and regulate emotions through a process of accepting, not avoiding, and then utilizing the emotion to improve coping (Greenberg, 2004).

These findings, especially with respect to the isolation process, support a humanistic approach to the prevention of suicide and treatment of suicidal feelings, such as that suggested by Rogers and Soyka (2004). To accomplish such a therapeutic task is to switch from "doing therapy" to "being present" in the psychotherapy process, as suggested by Rogers and Soyka. Therapist anxiety over such a manoeuvre is inevitable, especially given the acceptance of more traditional means of assessing and treating suicidal persons. These findings show a need for practitioners to be more sensitive to the emotional process in the suicidal person. Participants perceive therapists to be uncomfortable with suicide and therefore may not disclose their true suicidal feelings. This secrecy impedes recovery in many cases.

How does a clinician communicate that it is acceptable to talk about being suicidal, both at the outset and throughout counselling? The first opportunity for this discussion occurs when communicating limits to confidentiality, at which time a clinician can talk about what would happen if suicidal feelings are disclosed and get feedback about the client's comfort level with that plan. The nature of the referral is irrelevant when considering how much time should be spent on this matter because suicidal feelings do not discriminate. Particular consideration of issues of control and fear are important to address and acknowledge. Actions speak louder than words. Consistency with the parameters agreed upon in the beginning of a therapeutic relationship is the main key. The delivery of these actions in a humanistic framework, with empathic, validating, collaborative factors in a non-judgemental environment, provides this safety factor.

Another implication for counselling is related specifically to the blocking mechanism on the flow of emotions. In session, this blocking mechanism can have a number of different functions that must be investigated without interrupting the adaptive nature of the blocking mechanism if it is operating. These implications resemble those involved in finding equilibrium in the under- and overregulation of emotions (Greenberg & Bolger, 2001). Therapists are cautioned to be respectful of this blocking mechanism whether it is a healthy or unhealthy function. Recognizing this blocking mechanism is good information for both the therapist and the client to know what to do next in psychotherapy (e.g., assisting emotional expression or facilitating continued emotional control). Empathy has particularly important implications for psychotherapy. The development of emotion regulation skills is not a smooth process, especially in the context of being suicidal. Confusion and frustration over their emotional state is likely evident during that awareness process and validation of that difficulty is best acknowledged.

There are practical psychotherapy implications of this study. It is not the suicide assessments that need to change necessarily. Rather, it is the manner in which assessments are conducted that may lead to more favourable outcomes, which is consistent with recommendations by other researchers regarding the importance of therapist empathy and therapeutic alliance in collaborating with suicidal clients (Jobes, 2000; Jobes & Drozd, 2004, Michel et al., 2002). Otherwise, as these results indicate, therapist anxiety about working with suicidal clients influences the level of disclosure by the suicidal client. These results may be incorporated into any theoretical perspective. They are relevant to general psychotherapy processes inherent in all of the psychotherapeutic approaches, such as the therapeutic relationship and specifically with respect to demonstrating empathy and collaborating with clients on identifying safe interventions.

Training implications are informed by participants' experience of keeping suicidal feelings a secret in order to protect the therapist. Again, this protection of the professional can be addressed in the beginning stages of psychotherapy when confidentiality issues are discussed. Issues of transference and countertransference can be explored in supervision, preferably prior to the time that trainees have suicidal clients, although this is hard to know based on a referral alone. Trainee anxiety about working with suicidal clients must also be explored.

This study grounds our understanding of the emotional process of being suicidal in the suicidal person's experience. Moreover, it helps to bridge the scattered and fragmented nature of the existing suicide and emotion literature by bringing the focus back to the roots. It will hopefully generate validation studies and further useful therapeutic directions as well. Once researchers and practitioners are able to grasp an understanding of suicidal clients' emotional experiences, they may be in a better position to generate more successful methods of intervention.

Implications for Research

Future exploratory research should consider the function of Blocking as a voluntary or involuntary use of executive control, as reducing the activation of the emotions or avoiding emotions by generating diversionary thoughts. In a way, emotions are more complicated than memories in their suppression because, at least for some participants, the Blocking acts on an all or nothing basis, with emotions, at least for some people, whereas executive control over memories is more specific to those memories of focus, usually memories causing distress. Clearly, this area requires further investigation. One might consider the diffuse nature of emotion in the brain (Panksepp, 2000) and the parallel pathways of emotion and learning and memory in the brain (LeDoux & Phelps, 2000) in devising experiments to explain the Blocking stage of awareness.

As these findings were clearly unique to this select group of previously suicidal persons, future qualitative research should be conducted that considers similar areas of inquiry with specific populations considering gender and cultural differences with respect to suicide. Given the differential suicide rates for men and women, various age groups, suicidal persons who have not received psychotherapy, and different cultural groups, (e.g., the rate of suicide for the First Nations population in Canada far exceeds that of the remaining population: NCHS, 2003), similar methods of inquiry used in this research are recommended with the aforementioned groups.

This study explored more about what happens than how it happens in the emotional process of being suicidal. Although we know that awareness was the vehicle in the process, it was difficult even for these articulate participants, to communicate how that happened. Perhaps future investigations could more specifically explore this *how* component.

Many studies investigate trauma as a risk factor for suicide or suicidal ideation and behaviours as a symptoms of trauma (Ben-Yaacor & Amir, 2004; Cohen, 2003), but no located study has directly and empirically investigated suicide itself as a traumatic experience. Certainly, the experience of being suicidal and attempting suicide resembles post-traumatic stress symptoms.

Perhaps an investigation into this hypothesis would further shed light on the experience of being suicidal.

Limitations and Delimitations

The most obvious limitation in the proposed study is the use of a small sample size as is characteristic of qualitative studies. Interviewing ceased when saturation of the phenomenon was reached. The purpose of qualitative research is not to generalize but to understand. Thus, the small sample size is justified in that it allows readers to extract from the results what is meaningful to them, all the while sacrificing traditional goals of generalizability.

A second limitation involves the potential for lost or reconstructed memories and the reliance on self-report. In this respect, it may be difficult for the participant to recall the emotions or the impact of those emotions, or to distort memories. Even if there is no loss of memory or memory reconstruction, it may be difficult to accurately recapture the emotional experiences. However, qualitative research allows for the incorporation of reflection and insight in describing experiences. Other methods of collecting more immediate experiences were accomplished by including diaries in the analysis.

Due to the qualitative nature of the study and the need for a broad understanding of the emotional process of being suicidal, prior to focusing investigations, there are many demographic aspects that were not differentiated in this study. Given the exploratory nature of this study, gender, age, and cultural differences were not investigated. The participant group, although diverse in age, may not have been completely representative. Given the fact that men complete suicide more often than women and that the suicide rate for the Aboriginal population is estimated to be three times that of the average population, these populations require specialized research. This study is isolated to the individuals' emotional experience and so it does not take into account the neurobiological and genetic influences, or cognitive processes of being suicidal.

This study is isolated to persons with individual psychotherapy experiences and so should not be applied to clients of family, group and couple counselling or the suicidal persons who have not had psychotherapy as their experiences may be significantly different. The process of psychotherapy likely affected these participants' experiences. It does not include those who are currently suicidal. Further, the study does not take into account the theoretical orientation of the therapist or the therapists' perspective. Finally, the study does not represent processes involved in completed suicide. The participants in this study comprised of those who have survived suicide attempts and so may not necessarily apply to completed suicides, although, whether there is a significant difference in the two populations is questionable (Leenaars, 1996). It is important to know the processes of a nonlethal attempt. Such knowledge may shed light on the processes involved in keeping a person alive. Completed suicides continue to remain a mystery apart from data on psychological autopsies and suicide notes Shneidman, 1977).

Trustworthiness

The purpose of grounded theory research is to generate theory by allowing the emergence of theory from which verification studies may develop (Glaser, 1992). Its purpose is not to test theory or verify ideas or connections. Rather, credibility of the emerging theory stems from the process of "integration, saturation, and densifying" of the data (Glaser, 1992, p. 29). Again, grounded theory methods of analysis were used to generate insight and understanding, not theory, in this study. A grounded theory study may be judged according to its fit with the realities, its ability to explain major variations in behaviour with respect to processing emotion, and its flexibility to the integration of new concepts (Glaser, 1992). Credibility was achieved by including participants in the data analysis and using participants' excerpts to facilitate data analysis and communication of results. In this respect the concepts and categories are grounded in the clients' experience and thus meet the criteria for credibility.

Summary

This study involves the suicidal person's perspective of the emotional process of being suicidal, by acknowledging the complexity of that process in the context of Developing Emotional Awareness. In a field of literature rich with suicide correlates, this study is distinctive in its systematic exploration of the emotional process of being suicidal. Participants offered valuable perspectives into how they experienced the emotional process of being suicidal. Grounded insight from this study identified awareness as the main vehicle in the emotional process of being suicidal, signifying a learning process. This awareness process was examined over periods of high lethality and thereafter, with the speed of getting through the stages increasing with experience, probably due to the impact of awareness on the person's control over their emotional process, as illustrated in increased levels of problem solving and coping skills. The awareness lens demonstrated how a person goes from being suicidal to developing skills that reduce emotional intensity and increase emotional control through the person's developing sense of awareness and insight over their emotional process. These results imply that clients' developing awareness of their emotions plays a role in reducing lethality levels. However, this study alerts the reader to the potentially lethal possibility of allowing expressed emotion beyond the individual's threshold. As Greenberg warns us, emotions must be assessed according to their adaptability. It is my interpretation that these persons gain other coping skills via the guidance of their awareness of the process. Moreover, the results derived from this exploratory research expand upon previously quantitative methods, which bypass the person's valuable experience. Implications for practice include the necessity of trainees and experienced clinicians to examine their beliefs and reactions to suicidal clients so that a supportive environment is facilitated for exploration and collaboration. This research seems to have substantiated previous thought into the suicidal experience in psychotherapy (Shneidman, 1977, 1987) and therapy (Greenberg, 2002, 2004; Greenberg & Paivio, 1997).

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Appendix A

Bracketing

It is hoped that self-reflection of my own personal experiences with the phenomenon of suicide and its emotional correlates will help to minimize the interference of these experiences and beliefs on the data collection and analyses process.

Since the inception, and perhaps prior to that, of my dream to become a psychologist, I have been intrigued about how emotional releases "work" . Having had my fair share over the years, I have come to consider emotional releases as healthy relief mechanisms, ones that allow expression of important matters so that life can go on. Whether it about a serious family tragedy or a response to watching the movie *Beaches*, it felt good. In particular it felt good knowing that when a release started, it would help to transform the feeling inside so that the outside could be better dealt. There was never the fear that it was never going to stop or that I did not have control. In fact, having or not having control was never an issue. One can imagine my curiosity and naiveté upon having clients who went through a process of developing the skills to actually have an emotional release, let alone use that experience to transform meaning. What a privilege it became to walk that road with clients, a road that I had come to realize that I took for granted with my own family and friends.

Relative to my experiences with client emotional releases, I have had limited exposure to suicidal clients, until recently. Not having known anyone close to me who ha completed suicide my experiences with this tragedy were restricted to consoling a friend who experienced the grief of losing his friend to suicide. My naiveté met my curiosity at this time as my friend tried to understand how his buddy kept his suicidal feelings and plans such a secret. In fact, the community was also completely shocked about how such a healthy, happy young man could end his life. This young lad did seem happy in fact. I learned that he had decided to suicide prior to one last trip to his home province, which he planned to say good-bye to loved ones without their knowledge of his imminent departure. While he was home, he appeared happy, wanting to spend as much quality time with his family and friends as he could fit into the schedule. When he returned to his apartment, he carried out the lethal plan, to everyone's shock and disbelief. How could this be? It must have been an accident. Perhaps it was foul play.

More recently, as a psychologist on a psychiatric unit of a hospital, I have had ample exposure with patients who have attempted suicide, engaged in self-harm behaviours, and who have been at all stages of risk for suicide. These experiences are particularly important for me to bracket for two reasons. First, my employment spanned part of the analyses stage. Second, the population that I work with is specific in that it involves individuals struggling with eating disorders and co morbid affective and personality issues. Although all participants in this study have come into contact with psychiatry during recovery from one or multiple suicide attempts, not all participants have had consistent contact with psychiatric services. I have become more comfortable asking about suicidal experiences, doing suicide assessments, and assisting clients through the process of late. I think it is my comfort level that has increased; I cannot say for certain that my anxiety level about working with suicidal persons has decreased significantly.

An examination of my beliefs about my experiences as a professional is necessary in order to bracket those beliefs. I believe that, regardless of diagnosis, there seems to be individual thresholds for managing emotional distress. This threshold is a unique conglomeration of experience with distress, genetics, personality factors, and exposure to environmental modelling of effective coping skills for each individual. I believe that being suicidal has important communicative functions, telling the individual that something is not working in their experience, something feels awry in the most disturbing way and it is more important to stop the disturbance than it is to live. I do not consider suicidal behaviours to be behaviour problems. I do not believe that suicidal behaviours are intended to find attention, knowingly. I believe that suicidal behaviours correlate with limited coping abilities but I also know that persons with exceptional coping abilities can be suicidal. It is my hope that by consideration of these beliefs I was able to bracket them during the research process.

Appendix C

Informed Consent

I, ____________________, am aware that the purpose of this project is to understand suicidal peoples emotional experiences. Through the use of an interview format, I will be asked to describe my experiences in as much detail as possible. I will also be provided with the opportunity to write down my experiences for the researcher and/or provide journals or diaries of the time that I was suicidal. I understand that this project is being conducted in partial fulfillment for Doctorate of Philosophy in Counselling, under the supervision of Dr. Barbara Paulson of the Department of Educational Psychology at the University of Alberta. Jody may publish certain parts of the interview that have been cleared of identifying data in an academic journal but the main purpose of the data is for dissertation research from which a final document will be constructed. I agree to participate in this project and I am willing to share my experiences with Jody Sark. I am aware that one interview of approximately one hour and a half in length and will be tape recorded in order that it can be transcribed for later analysis. I realise that my participation in the study is completely voluntary and that I can withdraw from the study at any time without prejudice. If I choose to withdraw from the study, any information about me or any data that I provide will be destroyed. I am also aware that if discussion of my experiences raises any concerns for me that I wish to discuss further with a counsellor, Jody Sark will confidentially suggest individuals that I might contact. I am aware that all information associated with this study is strictly confidential and that my identity and that of any persons that I mention, will be known only to Jody Sark and will not be revealed at any time. When transcribing the interview recordings, Jody Sark will use pseudonyms (i.e., false names) for my name and for those of any persons that I mention. These pseudonyms will also be used in writing the final report. Any details in the interview recordings that might identify me will be destroyed. Interview recordings will be erased when the transcript has been completed. I am also aware that the information obtained from the interview will solely be used for purposes of this project. I am aware of the benefits that participating in this study has for me. They include a general knowledge and understanding of my experiences, acknowledgement of the work that I did in therapy, a sense of contribution to the field and other clients upon communication of the study, and a token of appreciation.

I,____________, give my informed consent to participate in this project.

Date ____________________

Signature of Participant ____________________

Signature of Witness ____________________

Telephone Number of Participant ___________

Special Instructions for Phoning: ____

Send Summary of Findings to: ____

E-mail Instructions: ____

During our final contact over the phone, we will examine my understanding of your experience. That is, after analysing the interview data, I will end up with a brief description of the essential aspects of your experience. We will discuss this final description in order to determine how accurately it describes your experience. After I have completed the study, I will share my findings with you if you wish to know about them.

I want to mention again that your participation in this study is completely voluntary. Also, all information will be kept strictly confidential and you can withdraw from the study at any time without penalty. If you decide that you no longer want to participate in the study, all information about you will be destroyed. I may publish certain parts of the interview that have been cleared of identifying data in an academic journal but the main purpose of the data is for dissertation research from which a final document will be constructed. It is possible that talking about your experiences may cause you distress. If this occurs, I will provide referrals to counselling services.
Jody Sark

Appendix E

Sample Interview Questions

Beginning the Interview:

I want to know about your feelings and emotions during the time that you were suicidal. First, can you tell what brought you to counselling? You can start wherever you want to. After the first few interviews, *What is important for you to tell me about your suicidal experience?*

1. ***Context:*** What brought you to counselling? What did that feel like?
2. Can you describe your experiences of the therapist?
3. How would you describe yourself emotionally?
4. ***Emotions/Thoughts/Physiological Component:*** Can you describe the emotions you had in therapy?
    a. What comes to mind when you think about your feelings during the time that you were suicidal?
    b. Tell me about what it was like to hurt.
    c. Tell me about wanting to hurt yourself.
    d. Where did you hurt?
    e. Tell me what it was like to feel like hurting yourself - what happened?
    f. Can you describe the hurt?
    g. What allowed you to feel the hurt?
    h. Tell me about when the hurt changed to better feelings.
    i. What impact, if any, did you emotions have on overcoming suicide?
5. Could you describe for me any thoughts you had prior to, during, and after experiencing that emotion?
6. What, if any, bodily sensations did you have while experiencing that emotion?
7. ***Process/Developmental Course:*** At what point in therapy did you experience this emotion?
8. Can you describe what happened in therapy before you felt that emotion?
9. Can you describe what happened over the course of the session you were working through that emotion?
10. Can you describe what happened in therapy as a result of your emotional experiences?
11. Can you describe any impact that your emotional experiences had?
12. What was it like after the session? How did you feel afterwards?
13. Can you describe your emotional experience outside of therapy?
14. Can you describe any turning points in therapy?

Are there any other questions that I could have asked you about your feelings in overcoming suicide?
Is there anything else you think is important for me to know?